Hospital Progress

GERIATRICS ISSUE

January, 1956

VOLUME 37 • NUMBER 1

OFFICIAL JOURNAL

OF THE

CATHOLIC HOSPITAL ASSOCIATION

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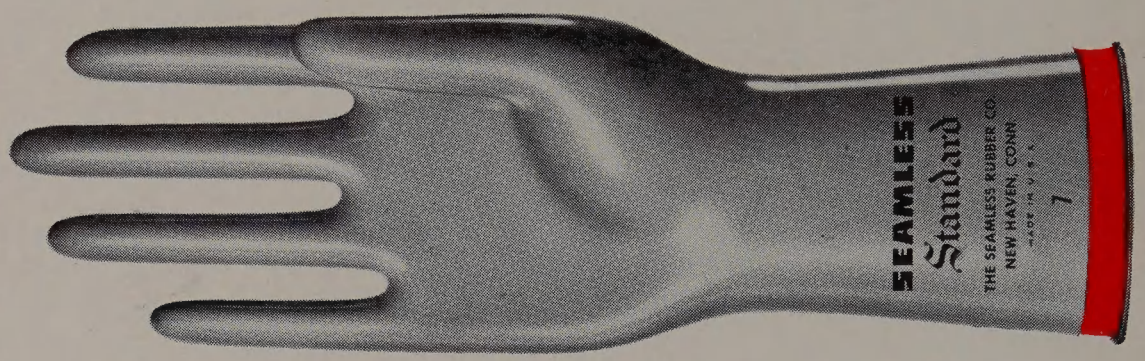

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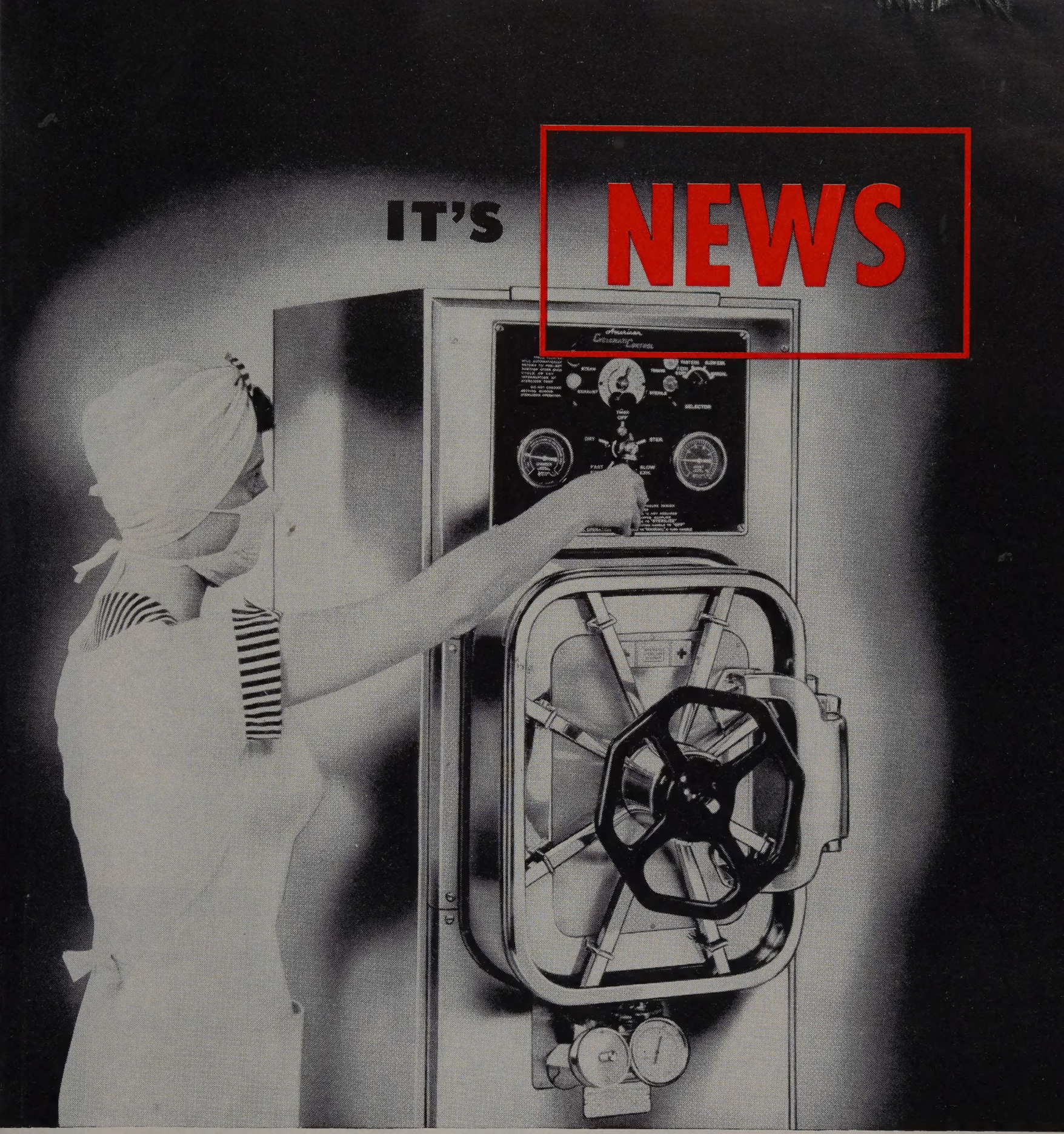

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JANUARY, 1956

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. . . . . JANUARY

Institute on Medico-Moral Problems (sponsored by The Catholic Hospital Association), St. Vincent's Hospital, New York, N. Y. **12-14**

Conference of Bishops' Representatives for Catholic Hospitals, Mid-Winter Meeting, Toledo, Ohio **18-19**

. . . . . FEBRUARY

Conference on Nursing Education (sponsored by the Conference of Catholic Schools of Nursing), Houston, Tex. **9-11**

Canon and Civil Law for Catholic Hospitals, Mayflower Hotel, Washington, D.C. **15-18**

. . . . . MARCH

Accreditation of Hospitals and Patient Care (sponsored by The Catholic Hospital Association), Spokane, Wash. **5-6**

Wisconsin Conference of Catholic Hospitals, Memorial Union, Marquette University, Milwaukee, Wis. **13-14**

Conference on Accreditation (sponsored by The Catholic Hospital Association), Mercy Hospital, Pittsburgh, Pa. **26-27**

. . . . . APRIL

Blood Banking Workshop (sponsored by The Catholic Hospital Association), Georgetown University, Washington, D.C. **2-6**

Texas Hospital Association, Dallas, Tex. **3-5**

National Catholic Educational Association, St. Louis, Mo. **3-6**

Texas Conference of Catholic Hospitals, Dallas, Tex. **6**

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. . . . . MAY

Massachusetts Hospital Association, Annual Meeting, Hotel Statler, Boston, Mass. **10**

American Nurses Association, Chicago, Ill. **14-18**

Conference of Catholic Schools of Nursing, 9th Annual Meeting, Milwaukee, Wis. **19-20**

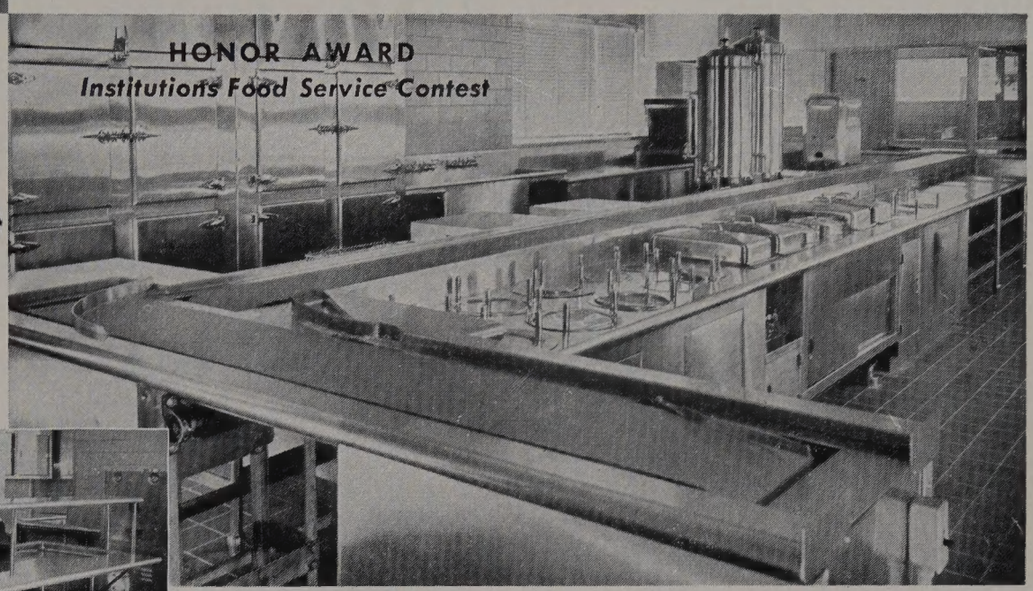
Catholic Hospital Association, 41st Annual Meeting, Milwaukee, Wis. **21-24**

ideas

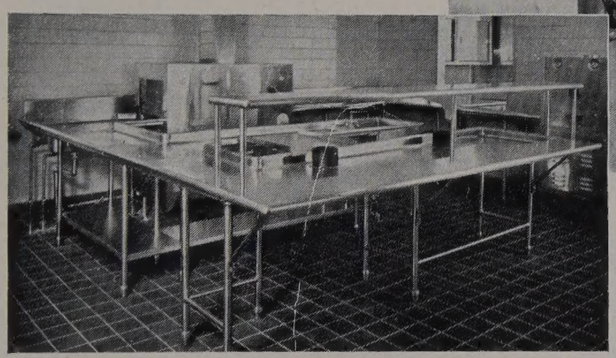
from Blickman-Built award-winning food service installations

tray production unit provides assembly-line efficiency

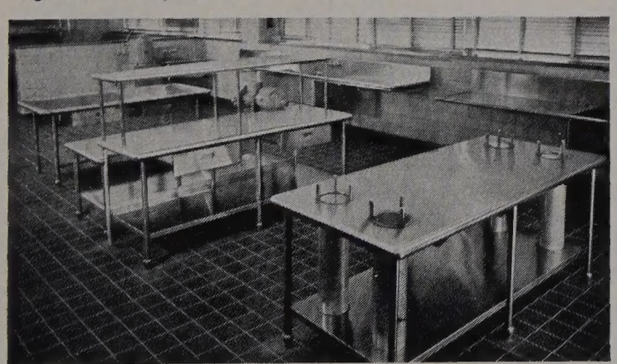
AT GREENWICH HOSPITAL, GREENWICH, CONN.



TRAY PRODUCTION UNIT in main kitchen, adjacent to cooking center. Trays move on long conveyor belt between two counters. Attendants load trays from both sides according to a card control which indicates special diets or patients' preferences. Note convenient placement of steam table, coffee urns, toaster, etc. Built-in "Lowerators" dispense trays and dishes at counter level. Loaded trays are placed in insulated tray trucks for distribution to patients.



MAIN DISH PANTRY, showing dish washer at left, glass washer at right. Long shelf in foreground holds trays during unloading process. Pass window at right opens directly to tray production area. Stainless steel dish tables are fully welded throughout. Round corners and seamless, crevice-free tops facilitate cleaning, assure hospital-standard sanitation.



SALAD AND VEGETABLE PREPARATION UNIT — View shows convenient position of work tables in relation to sinks. Note how ample spacing between units permits freedom of movement for personnel. These layout factors help speed procedures. Wall-mounting of stainless steel sinks in background eliminates leg obstructions, permits thorough cleaning of floor surfaces.

• By applying assembly-line methods to the distribution of food to patients, Greenwich Hospital has achieved substantial savings in time and labor. A mechanical tray-loading unit, located in the main kitchen, is the key to an efficient central service system. Trays, moving along a conveyor belt, are loaded by attendants from both sides. All equipment is conveniently placed to speed the operation. Insulated conveyors are used to distribute the loaded trays to the various floors. Food reaches the patients on time, kitchen-fresh and palatable.

The complete food service installation at Greenwich Hospital handles the preparation and distribution of approximately 1275 meals daily to patients and employees. Efficient work flow is achieved through carefully-planned arrangement and functional design of equipment. Seamless, stainless steel construction of individual units assures a high degree of sanitation and low maintenance costs.

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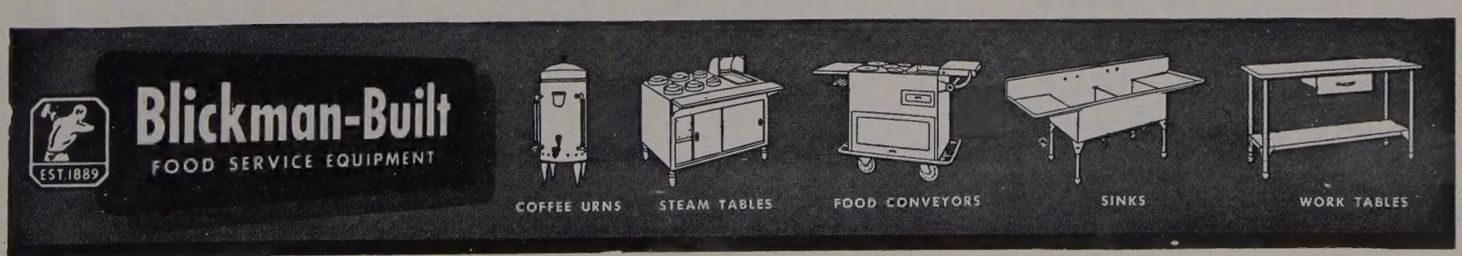

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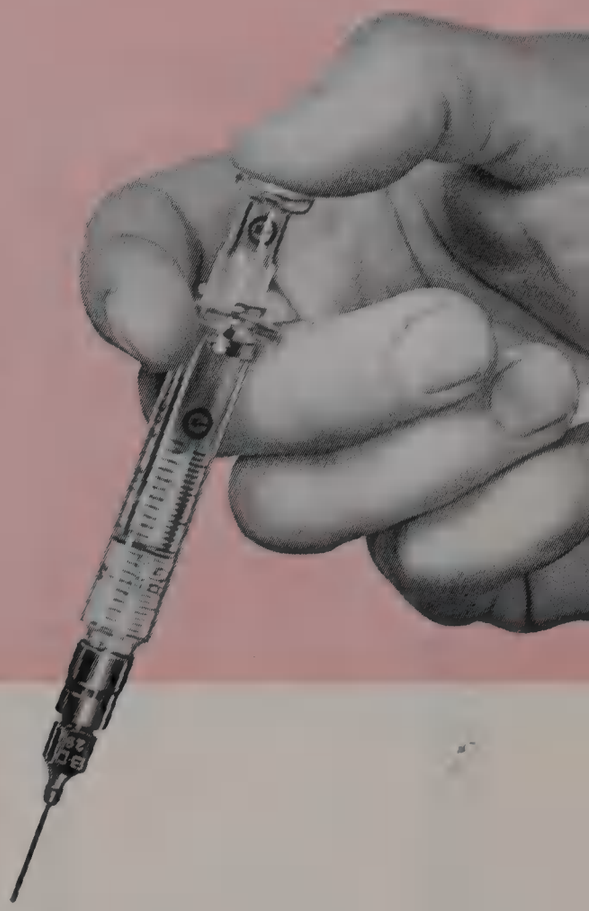

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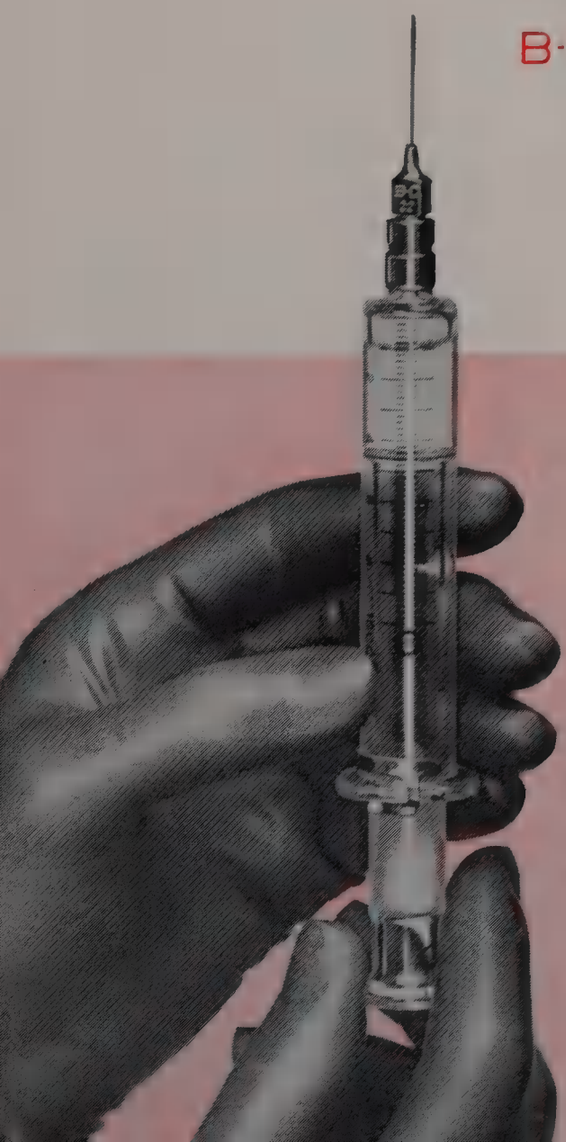

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EDITOR TALK

COMMENTS & GLEANINGS

The Editors present

. . . six articles dealing with Geriatrics in this issue. This topic is one which demands more and more attention from Higher Superiors, administrators and others responsible for the operation of hospitals.

The problem of caring for the aged is not new, of course; it has, however, increased in complexity and scope, principally because of two closely related factors:

(1) The amazing pharmaceutical developments of the past 25 years and advances in medical and surgical practice have protracted life expectancy for both males and females. These improvements in general care and in geriatric specialities give rise to the following statistics:

(2) The average expectation of life at birth has increased 18 years since 1900, and the number of persons 65 and over in the United States has quadrupled while the total population has only doubled. Fifty years ago, people past 65 were 4 per cent of the population; in 1950 they constituted 8 per cent; and 20 years from now, they will be 11 per cent of the total.

The Editors trust

. . . that every contributor, reader and correspondent found the Christmas season just past to be a hearty, holy period, rich in spiritual joys and satisfactions.

The Editors hope

. . . that 1956 will prove replete with happiness for hospital folk around the globe, and will bring prosperity, plus ever-improving care, to all hospitals everywhere.

The Editors regret

. . . that the Annual Index to the 12 issues of *HP* during 1955, was not completed and analytically reviewed in time to appear with last month's issue, as originally intended.

It had been planned to bind the Index with the December, 1955 number. This was, in fact, the procedure agreed upon at the Chicago conference of hospital magazine editors and others, regarding revision of current indexing practice [see *HP*, August 1955, p. 59]. Unfortunately, the production schedule of the Index did not coincide with that of the rest of the magazine, and it was necessary to go to press without inclusion of this valuable research tool.

Catholic "shehitah" . . .

Most nuns are unfamiliar with the terms "shehitah" and "terefah," but not the Sisters at St. Vincent's and St. Clare's hospitals in Manhattan and St. Joseph's in Far Rockaway, New York.

"Shehitah" applies to "kosher" food (i.e., prepared according to Jewish rabbinical law), while "terefah" refers to food not thus handled.

The food, prepared by kosher caterers, is frozen in an aluminum foil wrapping, which also contains knife, fork and spoon. In this way, complying with Orthodox ritual, neither utensils nor food are touched by unauthorized hands, for the patient himself opens the package.

This service, instituted "as a matter of religious courtesy," came into being at the request of the New York Board of Rabbis.

Grants & home care . . .

Washington Report on the Medical Sciences points out that "It is interesting that [the] Ford announcement [of its grants to hospitals] chanced to coincide with publication of a report which may give some hospitals ideas for putting their unexpected grant money to good use. Reference is to the monograph, 'A Study of Selected Home Care Programs,' a 128-page report on [an] investigation conducted under the joint sponsorship of Public Health Service and Commission on Chronic Illness."

Detailing 11 home care programs in 9 widely scattered communities, the report presents impressive evidence that, at relatively low cost, a hospital can develop a successful program of this type. It cannot only provide total extra-mural care for the patient, but also offer an excellent vehicle for the training of medical students, residents, nurses and social workers. Comprehensive guidelines for establishing such a program should be invaluable to any hospital contemplating such a step. ★

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Streptococcus salivarius	1:23900
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Neisseria catarrhalis	1:79000
Escherichia coli	1:11800
Salmonella typhsa	1:29000
MOLDS and YEASTS	
Saccharomyas cerevissiae	1:1980
Streptomyces gedanensis	1:1480
Actinomyces gedanensis	1:1480
Trichophyton schoenleini (Achorion schoenleini)	1:1300
Trichophyton mentagrophytes (Trichophyton interdigitale)	1:1000
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THIS MONTH *with the Association*

Sister Alice Regina Dies in Elizabeth, N.J.

Sister Alice Regina, Administrator of St. Elizabeth's Hospital, Elizabeth, N. J., passed away November 24, leaving to her community a record of accomplishment not equaled by many. Though 79 years of age, Sister Alice Regina possessed the spirit of one much younger. One of her last projects was the organization of a building program for St. Elizabeth's involving $5,000,000.

Sister Alice Regina came to the hospital field from a teaching career. In 27 years devoted to hospital administration, she gave to St. Elizabeth Hospital 18 years during which a great deal of the progress of this hospital took place.

Sister Alice Regina held a degree in sociology from Fordham University; she also attended the College of Pharmacy of Rutgers University; she was a Fellow of the American College of Hospital Administrators, a member of the New Jersey League for Nursing, the New Jersey Hospital Association and the American Hospital Association.

Requiescat in Pace!

Centenary Observance: St. Vincent's, Toledo

Commemorating the centenary of the Grey Nuns, also known as the Sisters of Charity, in Toledo, a program extending over a week was organized in large measure through the efforts of Msgr. Robert A. Maher, Diocesan Director of Catholic Hospitals, and President of the Catholic Hospital Association. One of the highlights of this program was the Solemn Pontifical Mass of Thanksgiving celebrated on Saturday, November 5. Participating were His Eminence, Samuel Cardinal Stritch of the Archdiocese of Chicago and their Excellencies, Archbishop Alter of Cincinnati and Bishop Rehring of Toledo.

Cardinal Stritch delivered the sermon on this occasion; while Bishop Rehring celebrated the Mass. Msgr. Maher and Father Flanagan also attended.

The centenary of St. Vincent's in Toledo affords some little opportunity to reflect on early Catholic hospitals in the United States. Organized approximately 27 years after DePaul Hospital in St. Louis (first Catholic hospital west of the Mississippi River) St. Vincent's historically ranks among the first of the Catholic hospitals in the United States.

Originating in Canada as a Canadian Order established in 1737, the Grey Nuns are widely represented in the Catholic hospital system of that country.

The Officers of the Association and the editors of HOSPITAL PROGRESS join in extending congratulations to the Grey Nuns of Toledo on this occasion.

30th Anniversary Salute to Mother Dengel's Sisters

Mother Anna Dengel, M.D., was lauded as one who "has done more for the missions than any woman living today." The tribute was paid by Bishop Fulton J. Sheen, national director of the Pontificial Society for the Propagation of the Faith, at a testimonial program in Philadelphia attended by some 2,000 persons to mark the 30th anniversary of the founding of the Society of Catholic Medical Missionaries.

At the same time, the National Federation of Catholic Physicians' Guilds of the United States hailed Mother Dengel "with prayerful pride" as "a professional equal and a spiritual superior."

Bishop Sheen spoke of the Christian regard for the body and of Our Lord's miracles of healing. He traced briefly the history of medical missions from the time of St. Luke to the present, accentuating the spiritual side of the medical mission apostolate.

In saluting Mother Dengel as the foundress of the Medical Mission Sisters, the Federation of Catholic Physicians' Guilds said she "had the daunt-

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THIS MONTH

(Continued from page 14)

less courage to pioneer in an uncultivated area of the Lord's vineyard."

The citation calls her Society "the first order of its kind in the Church's history," and says her work is "internationally and rightfully recognized as a modern spiritual medical crusade."

Mother Dengel will be remembered by many Catholic hospital Sisters for her contributions to their work, notably at the 40th Annual Convention when she was chairman of the special meetings dealing with "Health of Religious."

Alberta Conference Proceedings

The summary of the proceedings of the annual meeting of the Catholic Hospital Conference of Alberta held on September 14 and 15, 1955 at Calgary reached the Central Office recently. Sister Loyola, vice-president, commends the reading of these proceedings because of the "very enlightening and instructive conference program." Encompassing some 60 pages, the proceedings of the meeting include an extensive presentation of personnel procedures as well as other related materials.

Proceedings of Regina's Medico-Moral Workshop

Father Henri Légaré, O.M.I., Executive Director of the Catholic Hospital Association of Canada, has recently announced the publication of the proceedings of the Regina Institute on Medico-Moral Problems under the title "A Workshop on Medico-Moral Problems." Copies can be obtained from Father Légaré at 1 Stewart St., Ottawa, Ontario, Canada.

Minnesota Holds Annual Meeting

Nineteen hospitals were represented by Sisters attending the annual meeting of the Minnesota Catholic Hospital Conference on November 3 at St. Mary's Hospital in Minneapolis.

Bishop James J. Byrne addressed the group on "The Spiritual Life of a Religious in a Hospital." Sister Rita Clare, administrator of St. Mary's Hospital, retiring president, presided. A panel on "Hospitals and Accreditation" was given by Sister Ste. Marie, Baudette; Sister M. Assumpta, Hibbing; Sister M. Lenore, Little Falls; and Sister Margaret of Minneapolis. Sister M. Loretta of Brainerd was moderator.

Reports from the American Hospital Association and Catholic Hospital Association conventions were given by Sister M. Antonius of St. Paul and Sister Rita Clare.

Officers elected for the year 1955-56 include: *President*—Sister M. Loretta, St. Joseph's Hospital, Brainerd; *President-Elect*—Sister M. Lenore, St. Gabriel's Hospital, Little Falls; *Vice-President*—Sister Mary Brigh, St. Mary's Hospital, Rochester; Secretary—Sister M. Patrice, St. Mary's Hospital, Duluth; *Treasurer*—Sister Jeanne Constance, Community Hospital, Baudette; *Directors* — Sister M. Antonius, St. Joseph Hospital, St. Paul and Sister Mary Joseph, St. Ansgar's Hospital, Moorhead.

Better Records . . . . Better Patient Care

This was the theme of the annual meeting of the Mississippi Conference of Catholic Hospitals held November

(Continued on page 19)

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THIS MONTH

(Continued from page 16)

9 at St. Joseph's Hospital, Meridian. This year's meeting took the form of a Workshop organized by Sister Helen Marie, president, Sister Mary Emmeline, vice-president, and Sister Mary Noel, secretary-treasurer.

Appointed to be chairman of this Workshop was Sister Mary Camille of St. Joseph Hospital, Meridian. Also participating in the meeting was Msgr. J. B. Brunini, Director of Catholic Hospitals of the Diocese of Natchez, and President-Elect of the Catholic Hospital Association. On this Workshop program were Miss Mavis Phillips, who spoke on the "Uses and Purposes of the Medical Record," and Mr. F. J. Buchanan, Adjustor of Claims, U.S.F.G., who discussed the "Legal Importance of Medical Records."

Part of the annual meeting was devoted to the showing of the Association's new film, "The Dedicated," which was well received.

Newly elected officers to serve for the year 1955-56 are the following: *President*—Sister M. Emmeline, St. Joseph's Hospital, Meridian; *Vice-President*—Sister M. Noel, Mercy Hospital, Vicksburg; and *Secretary-Treasurer* — Sister M. Teresita, St. Dominic's Hospital, Jackson.

John Hurley, Nebraska's New President

John Hurley, business manager at St. Francis Hospital, Grand Island, was installed as president of the Nebraska Hospital Association at the annual convention in Lincoln on October 13-14.

The new president is a past vice-president of the Nebraska Hospital Association, state chairman of the Blue Cross Advisory Committee and editor of the *Nebraska Hospital News,* the group's official publication. A native of Omaha, he has been associated with St. Francis Hospital for seven years. Mr. Hurley is a veteran of World War II and served in the British Indies and at the Army's Convalescent Hospital in Daytona Beach, Florida.

New Jersey Conference Names Committees

The composition of five committees was announced at a meeting of the New Jersey Conference of Catholic Hospitals held recently in New Brunswick. Current hospital problems were discussed by approximately 50 Religious and lay personnel representing the 17 Catholic hospitals in New Jersey. The meeting was conducted by Sister Clare Dolores, administrator of St. Vincent's Hospital, Montclair, and Conference President.

Also present were the Archbishop's and Bishops' representatives of the New Jersey dioceses: Rt. Rev. Msgr. Thomas J. Conroy, Newark; Rt. Rev. Msgr. John J. Shanley, Paterson; Rt. Rev. Msgr. Francis M. J. Thornton, Trenton; and Very Rev. Msgr. Alfred W. Jess, Camden.

Those named to the five committees are as follows:

Hospital Administration—Brother Theophane, Alexian Brothers, Elizabeth; Sister M. Pierre, St. Francis Hospital, Trenton; Sister Mary Eleanor, All Souls Hospital, Morristown; Sister M. Paracleta, Our Lady of Lourdes, Camden; Sister Philomena Mary, Holy Name Hospital, Teaneck.

Hospital Financing and Auditing—Sister Marie Lefevre, St. Peter's Hos-

pital, New Brunswick; Sister Marie Barbara, Our Lady of Lourdes Hospital, Camden; Sister Joseph Vincent, St. Joseph's Hospital, Paterson; Sister James Joseph, St. Francis Hospital, Trenton; Sister Anna Miriam, St. Mary's Hospital, Orange.

Nursing Education—Sister Josephine Anne, St. Joseph's Hospital, Paterson; Sister Ruth Hickey, St. Peter's Hospital, New Brunswick; Mrs. Helen McAllen, St. Mary's Hospital, Orange; Mrs. Mary Bobeck, St. Michael's Hospital, Newark; Miss Virginia Giganti, Holy Name Hospital, Teaneck.

Nursing Service—Sister Elizabeth, St. Francis Hospital, Jersey City; Sister M. Carla, St. James Hospital, Newark; Sister M. Noreen, St. Mary's Hospital, Orange; Sister Martha Mary, Our Lady of Lourdes, Camden; Miss Mary Fanning, St. Mary's Hospital, Hoboken.

Blue Cross and Other Third-Party Purchasers—Sister M. Cletus, Holy Name Hospital, Teaneck; Sister M. Wendalina, St. Clare's Hospital, Denville; Sister Eileen Theresa, St. Mary's Hospital, Passaic; Sister Mary Francis, St. Mary's Hospital, Hoboken; Sister M. Arnulfina, St. Francis Hospital, Jersey City.

● ABOUT 19 MILLION PERSONS—one out of every eight in the population—entered a hospital at some time during 1952, notes a new report of the Twentieth Century Fund.

Louisiana Conference Meets at Baton Rouge

The 1955 meeting of the Louisiana Conference of Catholic Hospitals took place on November 9 at Our Lady of the Lake Hospital, Baton Rouge, conducted by the Franciscan Sisters of Calais. Sister Carlos, president of the Conference, prepared and directed the program.

Included were topics dealing with public relations presented by Father Flanagan, Executive Director of the Association, and Sister Veronica of Mobile, Ala., a member of the Association's Executive Board. Following was a panel discussion in which in addition to the program participants the following individuals took part: Robert A. Pascal, Professor of Law, Louisiana State University; S. E. Burgoyne, Business Director, St. Francis Hospital, Monroe; and William O. Maloney, Director of Personnel-Public Relations, Hotel Dieu Hospital, New Orleans.

Regular Meeting Philadelphia Conference

Msgr. Fink, Moderator of the Philadelphia Conference of Catholic Hospitals, together with Sister Mary Michael, vice-president, and Sister M. St. Robert, secretary, arranged that the quarterly meeting of the Philadelphia Conference for October 1955 coincide with the Regional Conference dealing with "Hospital Accreditation and Patient Care" scheduled in Philadelphia October 31-November 1. Msgr. Fink was the celebrant of the Holy Mass opening this Conference, and His Excellency, Archbishop O'Hara of Philadelphia extended greetings.

Participating in the Conference program were Msgr. D. A. McGowan of Washington, D.C., Dr. Anthony J. J. Rourke of New York, Mr. Charles E. Berry of St. Louis, and Rev. John J. Flanagan, S.J., Executive Director of the Association. ★

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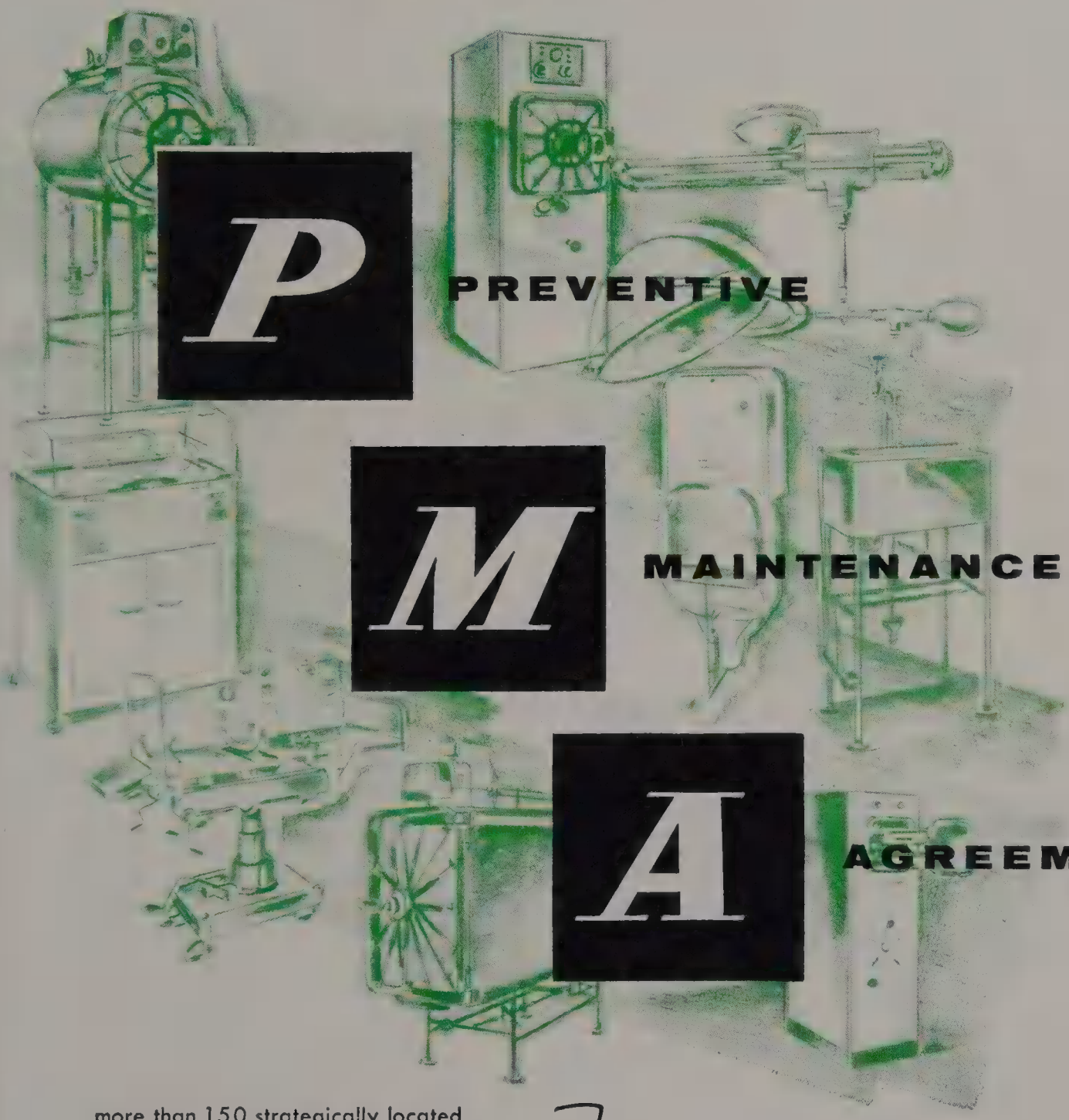

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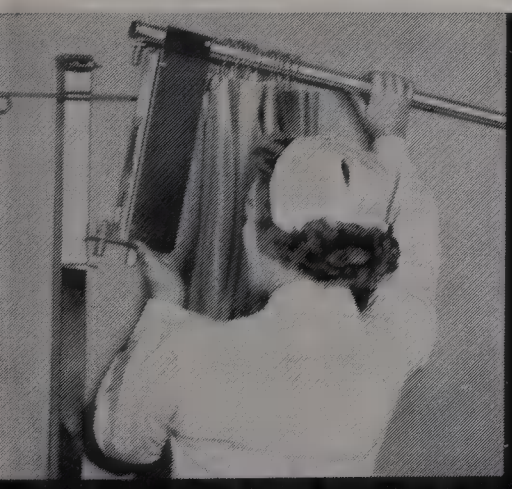

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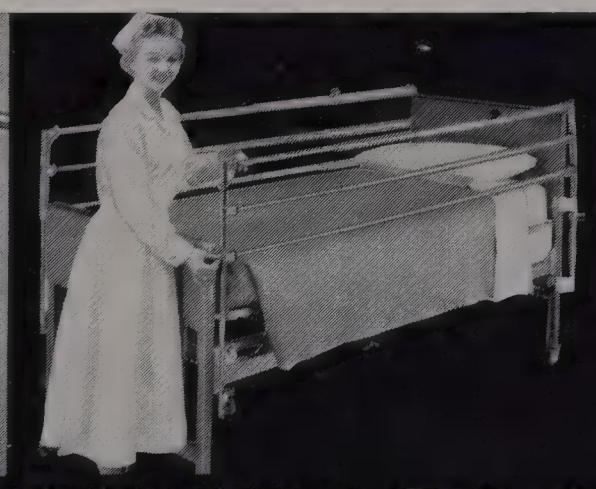
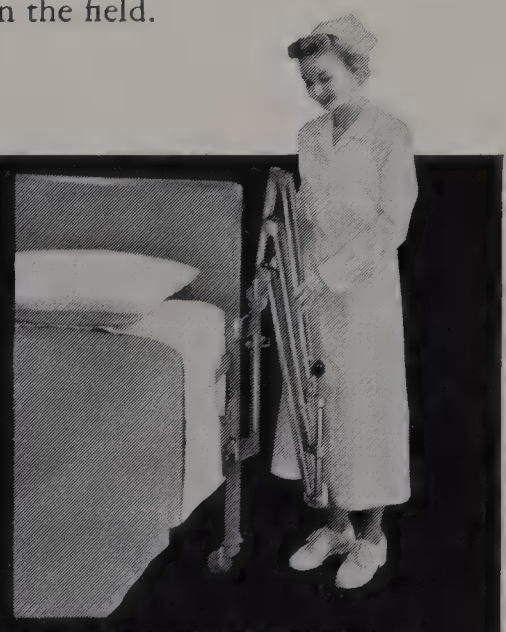


TOMAC Telescopic Safety Sides shown fully extended. Nurse is tightening thumb screw which holds sides securely. Lightweight and convenient, yet ruggedly constructed. Specially designed clamps allow TOMAC Safety Sides to be fitted to all standard beds.



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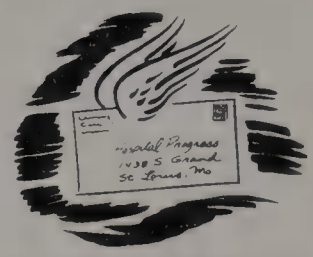
LETTERS TO THE EDITOR



To the Editor:

This hospital is interested in reproducing an article entitled "The Patient's Stake in Accreditation," by Dr. Robert S. Myers, which appeared in the August 1954 issue of your magazine.

We would appreciate your granting us permission to reproduce this timely article for distribution to the patients in our hospital.

Yours very truly,
LOUIS M. DYER
Hospital Administrator

Steptoe Valley Hospital
East Ely, Nevada

☆

To the Editor:

In recent months I have missed the articles on medico-moral problems which used to be featured in HOSPITAL PROGRESS. These seemed an integral part of the magazine, and—because of their authoritative theological opinion—were obviously not duplicated elsewhere among journals in the hospital field.

When can we readers expect to see more of them?

Very truly yours,
WILLIAM BOLTON

Minneapolis, Minn.

☆

To the Editor:

I just went through the Mental Health features in the November issue, and find the material instructive, interesting and—what is more—easily assimilable. Especially valuable, it seemed to me, was the article by Dr. Karl Stern, which co-ordinated the Catholic viewpoint with that of psychiatry in a novel way.

It was not too soon for another issue emphasizing this subject, and I'm looking forward to another in the months ahead.

Sincerely,
LOU HOLTMAN

Los Angeles, Calif.

To the Editor:

Enclosed is the questionnaire [on reader preferences for the content of HP's new Housekeeping Department] you sent some time ago. I hope this is not too late for your use. We are very interested in HOSPITAL PROGRESS and practical literature of this kind in the hospital field.

Sincerely,
JOHN HOLMGREN
Administrative Assistant

Hospitals' Central Office
Sisters of St. Joseph
Wichita, Kans.

☆

To the Editor:

We are writing to ask for some reprints. In the HOSPITAL PROGRESS for July, 1955 an article was written titled "A Joint Committee Spurs Better Care." The writer of this article was Sister Thomas Francis of Hartford, Conn.

Will you please send 24 copies of this reprint so that we will have it available for the members of the state Committee on the Improvement of the Care of the Patient? We would appreciate receiving these as soon as possible.

Sincerely yours,
HAZEL E. GABRIELSON, R.N.
Executive Director

Michigan State Nurses' Association
Lansing, Mich.

☆

To the Editor:

The senior class of students wanted a field trip to other hospitals, but we didn't think that was feasible and instead we showed the film [*The Dedicated*]. Their response to the film was very good, from the historical as well as current point of view. The students were impressed with the clear demonstrations of actual situations.

Thank you for your co-operation.

SISTER MARY JUANITA, S.S.M.

St. Louis University School of Nursing
St. Louis, Mo.

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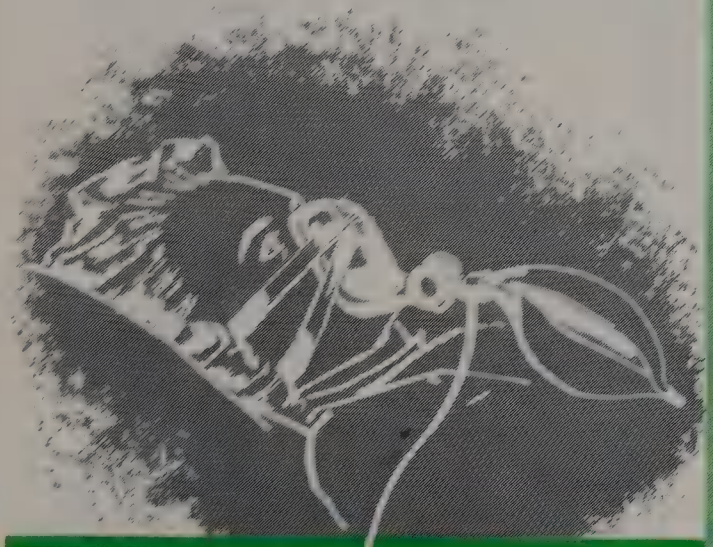
OR SMALL



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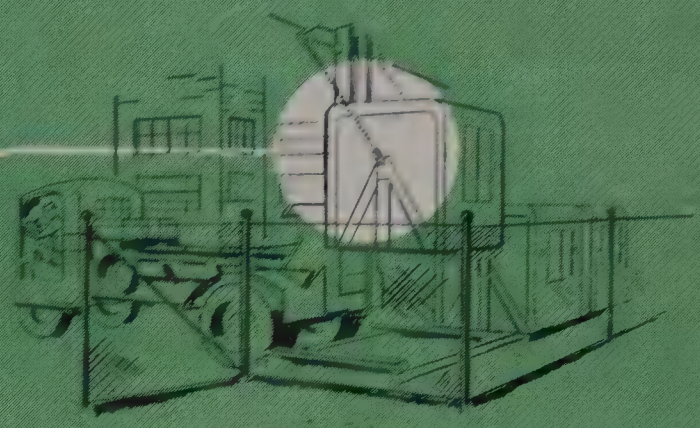

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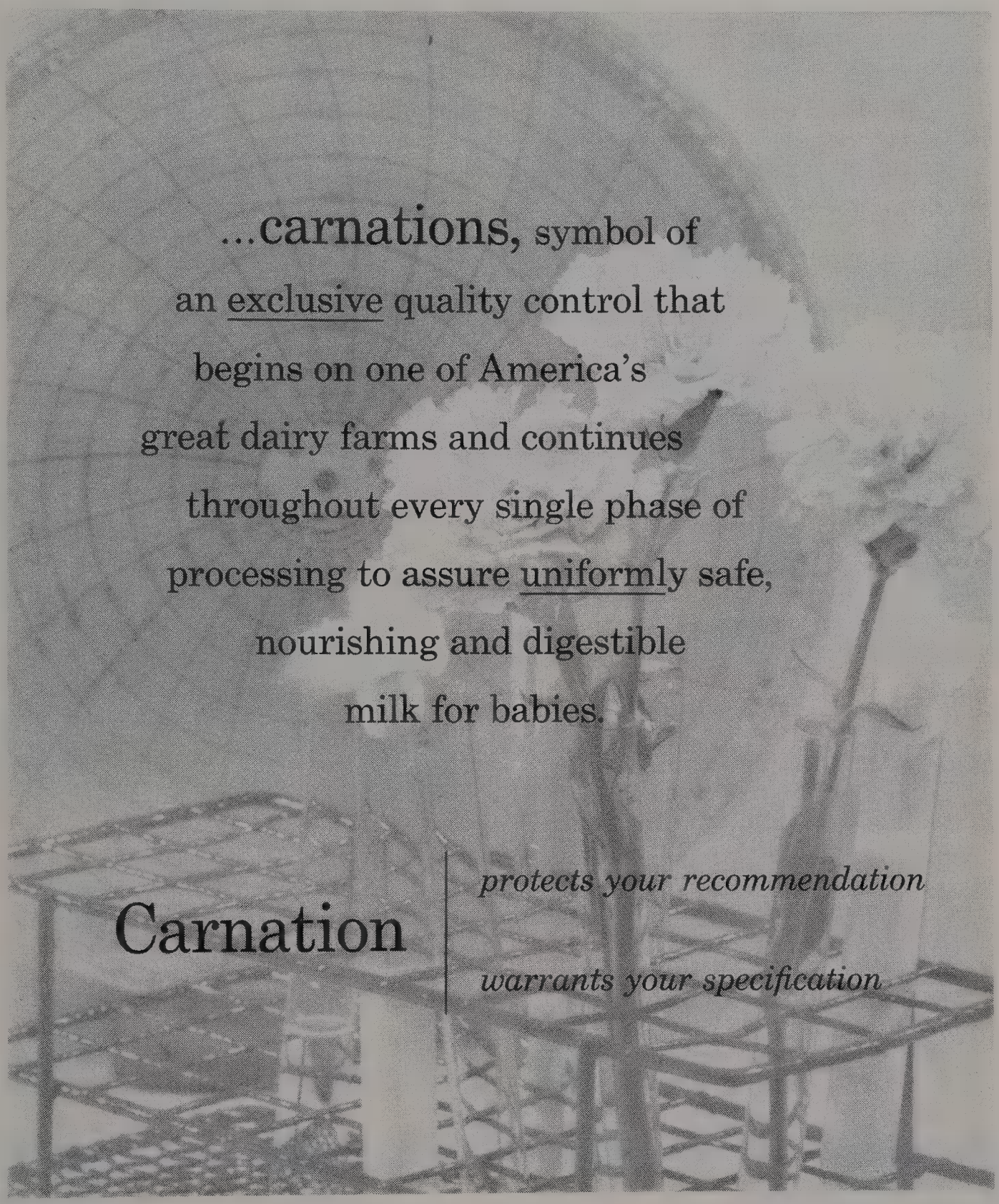

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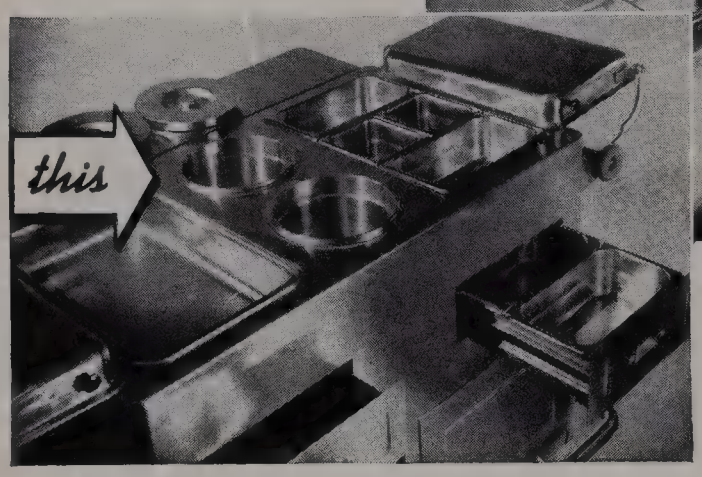

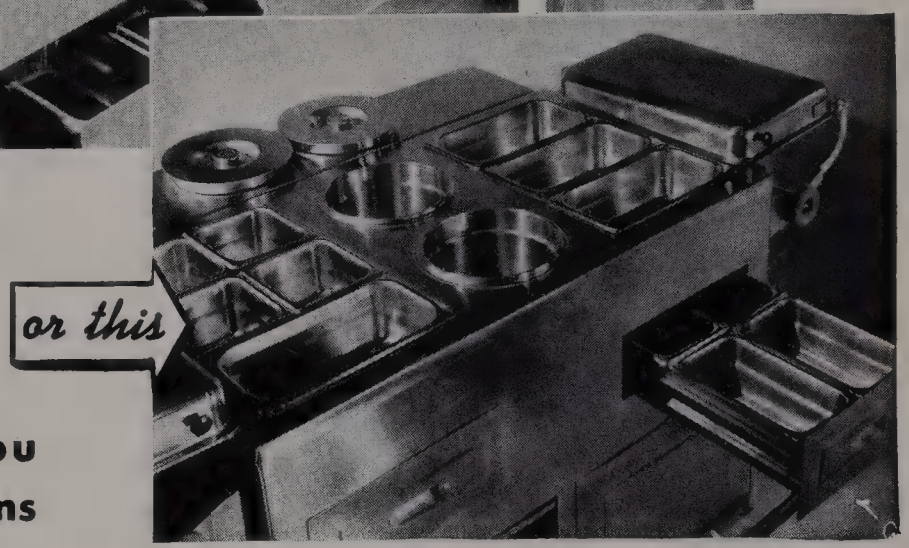

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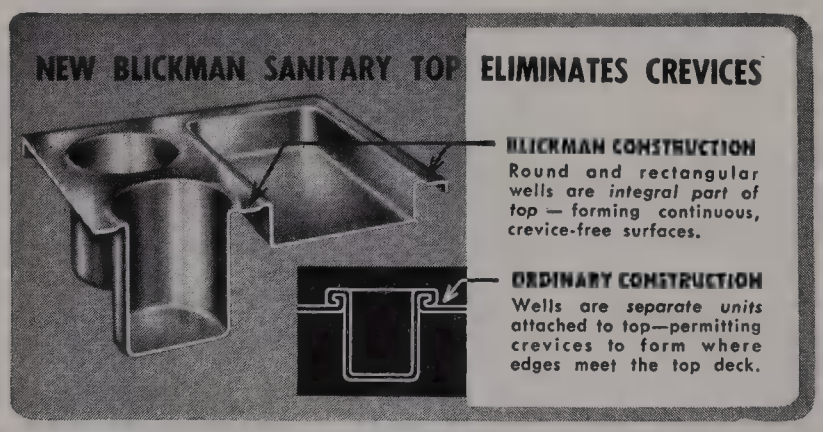

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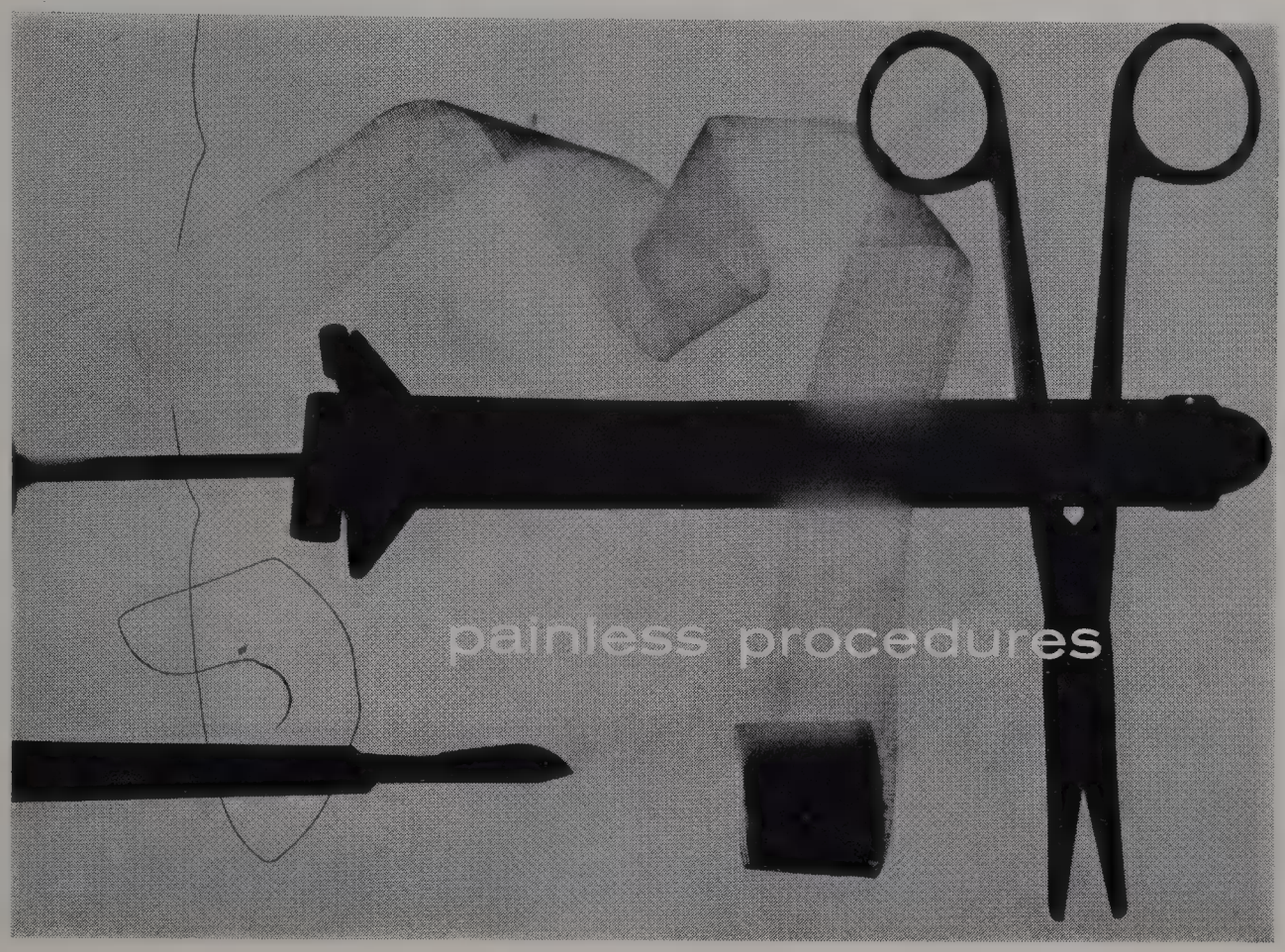

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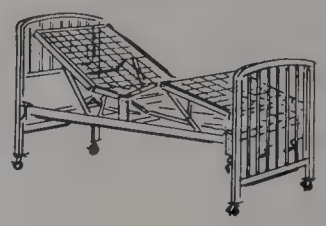

587
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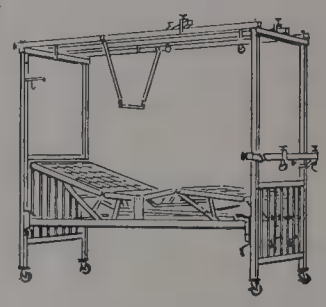
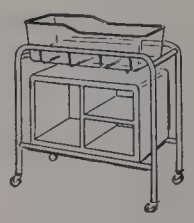
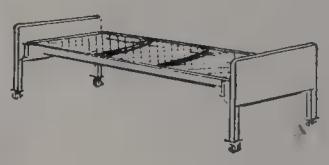




88
Bassinets

106
Cribs



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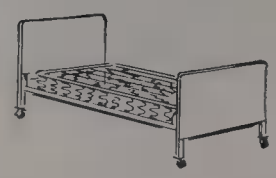

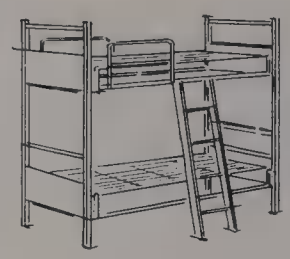

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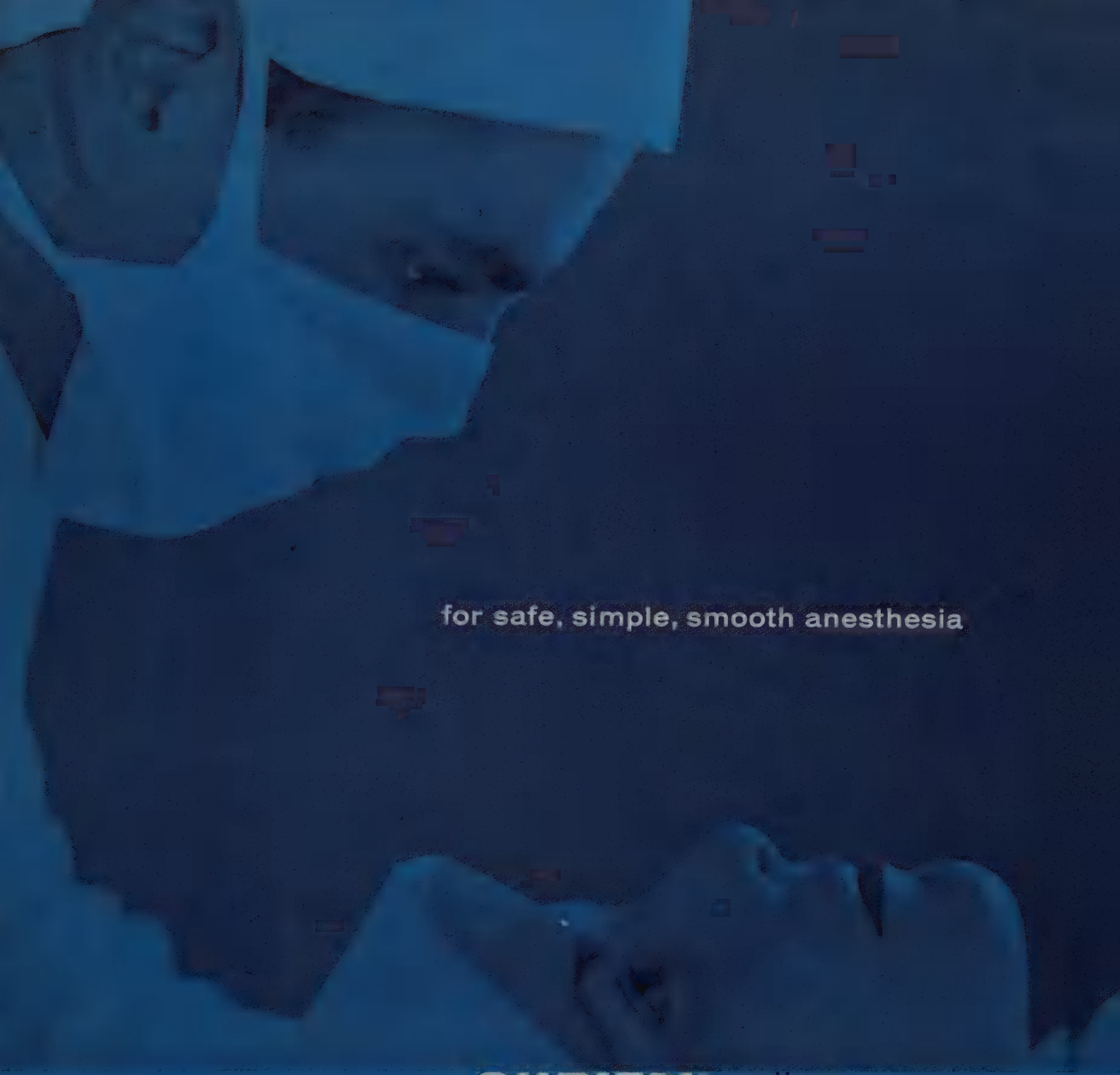

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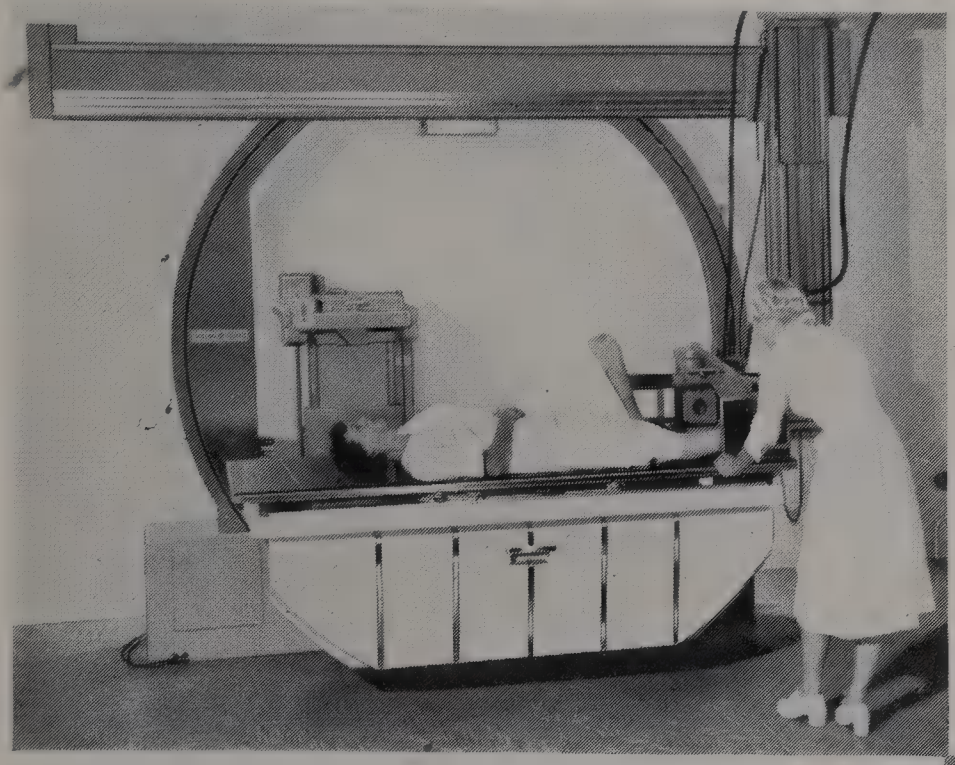

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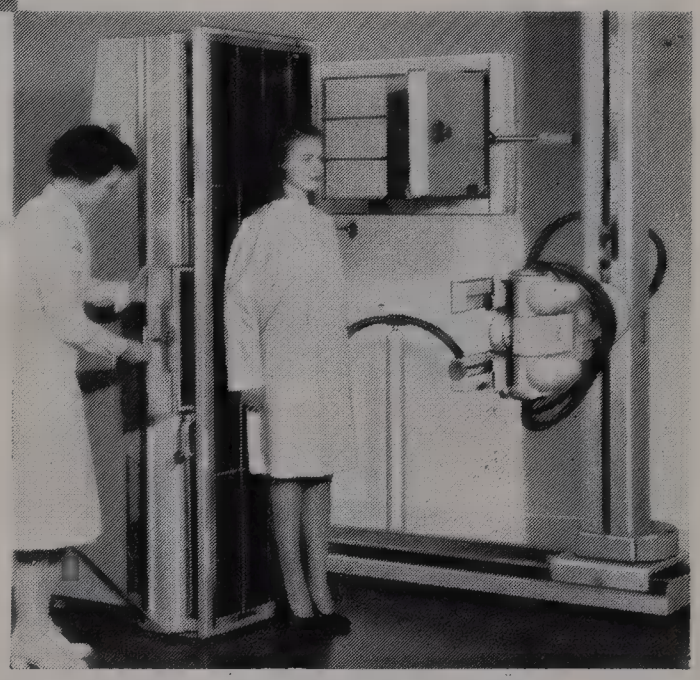

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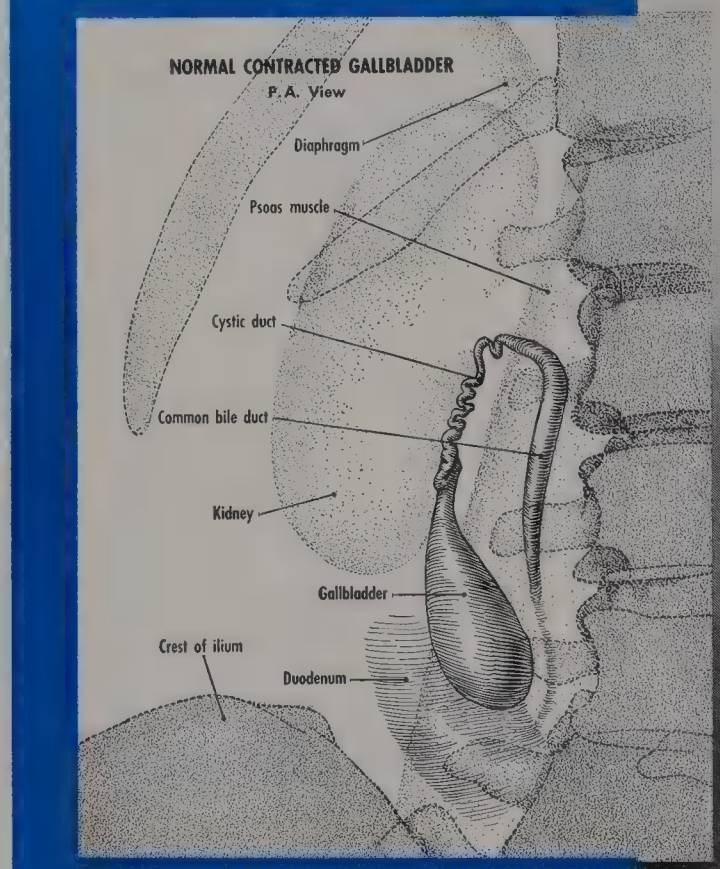

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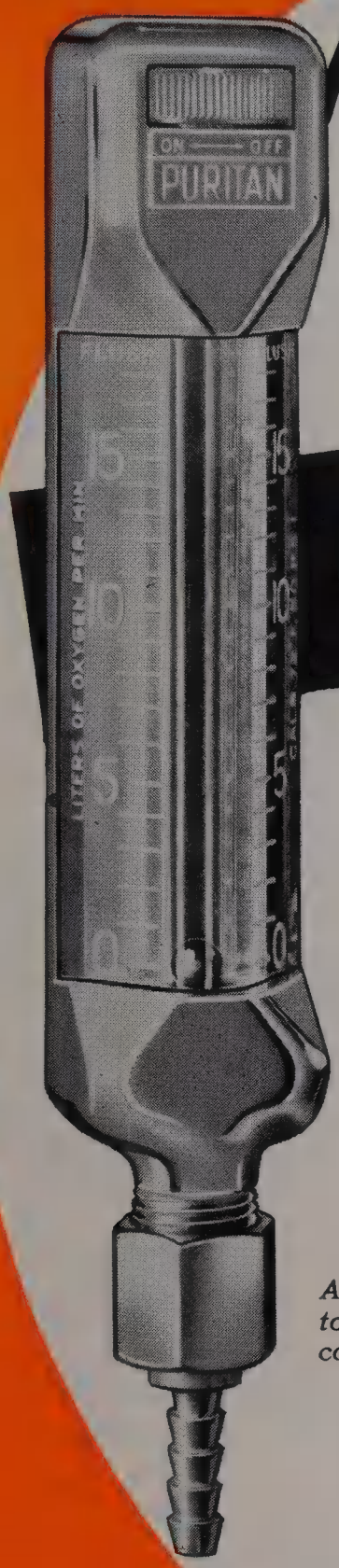

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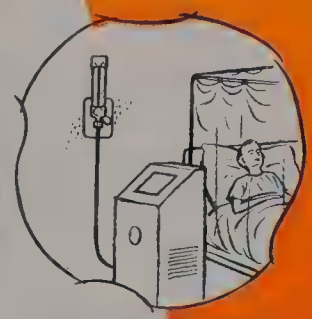

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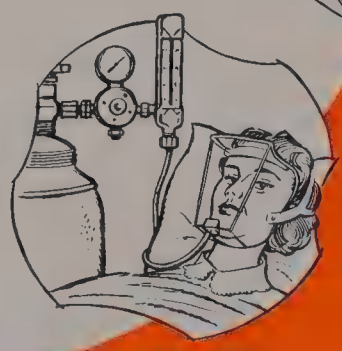

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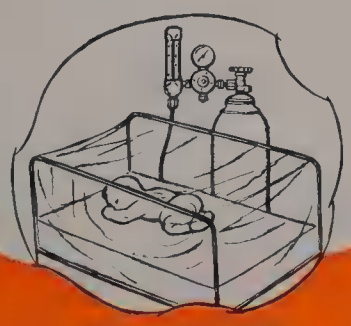

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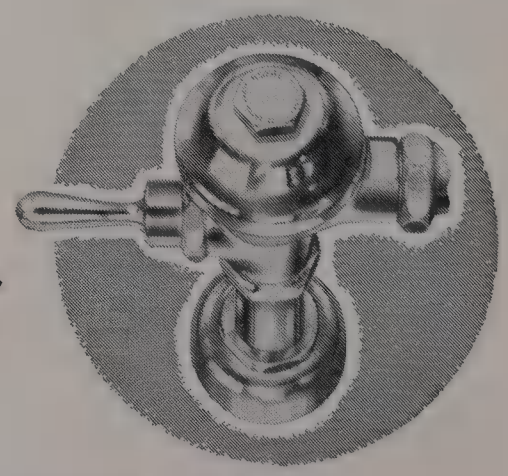

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PRESIDENT'S EDITORIAL

Is Laicization Endangering the Catholic Spirit of Our Hospitals?

AT THE BEGINNING OF A NEW YEAR, an old saying goes, "Count your blessings!" Among many blessings, one of the greatest is our Catholic hospital. Spread across the width and breadth of the United States and Canada, our hospitals are appreciated by all, used by all. To the active, zealous, self-sacrificing men and women of religion who have brought and are now bringing to us Christ's own mission of healing in the services of our Catholic hospitals, we raise our hearts in profound thanks and earnest acknowledgement during this and every year.

From the past we received the precious heritage of hospitals which are truly spiritual in concept and in operation. The sacred and urgent responsibility falls upon us to keep our hospitals truly Catholic in atmosphere and in service. This blessed advantage of Catholic hospital care among us calls for not only effective practical planning to ever extend and improve but also it calls for alert watchfulness for dangers which might threaten the traditional religious spirit and motivation of our institutions.

Currently, there is considerable comment and genuine concern over a real danger to the spiritual life of our institutions (and hence to the essential and fundamental reason for their existence). Because this danger has developed gradually, it may have gone unnoticed by some. Here and there this danger may not be imminent but in many other places, its harmful effects are being felt right now and definitely will be felt by all in the future, unless we find corrective means to offset its harm.

This problem of which we speak results from the constantly increasing number of lay workers whom we employ or who associate with us on our staffs. Within the last quarter of a century, the per cent of lay personnel to Religious has grown greater and greater. So, today, it is not uncommon to hear a patient remark, "Where are the Sisters?" Sisters or Brothers are not too much in evidence from the viewpoint of direct patient care due—as we all know—to the necessity of other duties. Consequently, the immediate helpfulness to the patients must be carried out by those we employ. Surely, some of our lay help do have a spiritual viewpoint, and are prompted by love of neighbor for love of God in their work, but by and large, there is lacking the religious attitude toward the patient which a consecrated person does have. These people are not nuns or Brothers. Consequently, unless Christian teaching is manifested in some way among our personnel, their attitude and patient contact will not differentiate our service from any other non-religious institution and will definitely tend to secularize our hospitals.

True, many of our hospitals today do still have a Sister supervisor on each ward with all nurses, personnel and patients under her direction. On the other hand, many hospitals do not have a Religious for every floor or department. Let us be honest—their number is increasing. Large hospitals are being run by less than a dozen Sisters. One 200-bed

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hospital has five Sisters. Another 600-bed hospital has sixteen Religious. So go the figures, which can be checked in the HOSPITAL PROGRESS Directory.

Such a situation neither hospital Sisters nor Brothers wish for or sought. Appreciative as all are of lay assistance and with no thought of depreciating the fine co-operation and excellent work which they do, nevertheless, this out-of-balance and ever-growing percent of lay personnel to Religious in offering care to the sick is certainly not the ideal of our Sisters and Brothers. Nor do the laity, on the other hand, wish for such a situation in a Catholic hospital for they, too, see their own inadequacies where a Religious is expected, and they look for the direction and supervision which the presence of a Sister alone can provide. Moreover, all who are interested in or who have responsibility for our institutions pray daily for more and more vocations to the Sisterhoods and Brotherhoods of those Orders sponsoring hospitals. Their vision beholds all hospitals adequately staffed with dedicated lives living out of the Charity of Christ as they tend the ill and the injured.

The demand, however, for new Catholic hospitals, or for the expansion of existing facilities, required our Religious to call in lay help if the greater responsibilities are to be assumed. To use an expression —"They have spread themselves thin" in their generous, self-sacrificing, response to furnish to as many as possible the blessed care which only vows and a dedicated life can provide. Besides, the whole complexity of modern hospital management and service so necessary in benefiting patients with gains and advancements of medical and nursing science, calls for more and better-trained persons than under old methods and in former years.

The danger is with us. Will we then be able to preserve and foster the religious spirit and atmosphere of the past in our hospitals when the greater majority of those ministering to the patients or fulfilling other duties and responsibilities are not Religious? Will we gradually become secularized institutions? This must not happen. Our hospitals are profoundly and essentially different because Christ is the Founder. He lives in our hospitals in the performance of His acts of Charity by all. His teachings are exemplified in the very way we care for the sick. We must find an answer to this, our present and ever-increasing problem, if He is to continue to dwell within our institutions.

Suggestions have been made such as a constant program of orienting our employees to our objectives and aims as outlined in the Presidential address last year [HOSPITAL PROGRESS, July, 1955, page 46]. Another suggestion calls for a Religious who would constantly visit all segments of the hospital each day. Her duties would be not only to call on patients, similar to the spiritual hostess functioning in many hospitals today, but also this Religious would daily be available to all staff members and employees as a consultant, advisor, or even as an over-all supervisor, or assistant administrator. There must be other suggestions, methods or means to alleviate or solve this problem. It demands our serious attention. We ask that you give thought to this danger. It is here. We must face it. ★

—RT. REV. MSGR. ROBERT A. MAHER

Geriatrics in Perspective

There are various approaches to the many problems presented by our aging population. Which will ours be?

by F. JAMES DOYLE, Associate Editor

THERE ARE THREE WAYS (at least) of looking at geriatrics: (1) "Sentimental," (2) "Scientific" and (3) "Realistic." The first two have been tried without sufficient effect to be meaningful.

The "sentimental" approach has resulted perhaps in as much woe as weal. The problem of "youngsters" yoked with "oldsters" in the confined quarters of modern apartments is a real one. Only the Chinese tradition and some of our more familial-oriented forebears can manage today this juxtaposition of generations which seem to have little in common—and to be actually, because of changing mores, practically hostile.

The purely "scientific" approach, though it documents the problem with a great many facts, has little opportunity to do anything about its fact-finding. Its contribution is essential to rational action, but is not in itself the spur to it.

We come then to what may be called the "realistic" attitude. A "realistic" attitude should not only contemplate action, but require it.

This means finding an answer to the question, "What must be done?" (in the light of the need and of our obligation under Christian charity to fulfill it). It is hoped that some answers will be found in the section of this issue devoted to the topic.

There is no doubt that a need exists for wider, more intensive geriatric care—and that this need will increase. We may then ask ourselves, "What kind of care is needed now? To what extent will this need increase?" One question alone is an involved one: "How will geriatric care affect that of acute cases?" In other words, to what extent will it supplement or replace present emphasis?

What is happening to our old people? Do we know? We certainly do little comprehensive planning for them. Most efforts to do so seem to be sporadic, temporary and local. These praiseworthy attempts, while not negligible, are plugs in marginal dykes, not new dams in an over-all national program of conservation.

Some of our "accent on youth" (which seems to have accelerated delinquency) might well be directed instead toward a more positive goal: an "accent on age"—and the continuing contribution which the so-called aged could make, were they not shoved into premature senility by our American fetish of immaturity.

The problem concerns sociologists and economists; psychologists and psychiatrists; directors of health facilities, medical education and research; including the military, Federal and state governments; industry (both managerial and labor aspects); and every family unit in the nation.

Of what elements does this comprehensive problem consist? For the sake of simplification, they might be reduced to the following essentials, which when fulfilled, afford "security."
(1) Material: (a) Food (b) Shelter (c) Clothing
(2) Psycho-Spiritual: (a) Status of being loved, wanted or needed by relatives, *et al.* (b) Spiritual satisfaction in communion with God.

The first category is the more obvious one. And while we may approbate our Social Security (O.A.S.I.) advances, we need not be too pleased at these, or consider them the end-all of our endeavor.

In Europe, among other examples, Denmark, Great Britain and Belgium, have outdistanced us completely.

The second category—that of psycho-spiritual necessities—is in one sense even more difficult—and, in another, simpler.

Provision of human affection to and around the aged cannot be resolved simply. The intangible complexity of an individual psychological make-up is not comprehended, destroyed or altered by broad planning. Each family situation, admittedly, is in a sense unique. But there is no computing the possible result on these familial situations—of better material planning as is exemplified in the first category.

The second part of the psycho-spiritual realm holds less difficulty, because the ministrations of religion—its consolations and fulfillments—are generally available no matter what the economic, social or chronological status of the communicant.

What positive recommendations can be made?
(1) Establishment of housing projects for the aged in connection with and/or in juxtaposition to a medical center (or some institution for complete acute care).
(2) Surety that adequate spiritual care facilities are available at all times. (This would mean a kind of chaplaincy for each such geriatric center, if extended enough—or for a "circuit-riding" chaplain for a series).
(3) Incorporation in the construction of such geriatric centers, of all physical and psychological features already proved desirable. ★

Geriatrics in the General Hospital

A first-hand, warmly-human recital which illustrates that while surroundings are important, attitudes are more so—with important results on nursing education

by SISTER M. FRANCINE, F.S.P.A. ■ St. Anthony Hospital, Carroll, Iowa

THE FOLLOWING ACCOUNT is a discussion of how an interest developed in the care of the aged, what brought it about, some of the results, and how an educational program emerged in a general hospital which became the first hospital in Wisconsin with a segregated service, course and experience in Geriatrics for student nurses.

In 1950 a new assignment took me from a very active surgical and medical ward of 55 bed patients in Iowa to a semi-active ward of 37 beds in Wisconsin. The situation looked dull —and became sultry before many weeks slipped away. This ward was a mixture of acute medical patients, chronically ill patients, paralytics, senile dementias, patients who had no home or were unwanted by relatives.

Human pride can be put to good use at times. Why let a situation lick one? Why not let it be a challenge? What were the possibilities of getting at the bottom of the trouble? This is what a good surgeon or physician would do. If you want to be a good head nurse, that is what you had better do, too. Was there trouble? Oh, yes, this department of the hospital had a name—one it had had for years.

Physical examination of the ward revealed these ailments: Frustrated personnel, more or less at all levels, a terrific environment, and a group of about seven patients who had the ward well in hand. They were "characters." Their tenure of office outran all but three of the personnel. One good guess would account for the division's reputation so innocently acquired.

Just to get things moving, the environment was attacked first. It is astounding what paint, drapes, and rearranged furniture will do. It worked like a miracle drug on the ward atmosphere. The listless maids took a new interest in keeping the rooms clean. The staff nurses came up with fine ideas and the majority of patients beamed, for it was all for them. Our "senior" guests watched it all with a gleam in their eyes, and an inscrutable expression.

One fine day during the usual morning call, one of them asked: "When are you going to fix my room up nice? I've been here the longest."

"Whenever you wish, but, of course, there are some conditions before this can be arranged.

It took about one hour and a half to get the conditions across with cautious wording and at the same time winning her confidence. In summary, those conditions were, in exchange for the "new look," to dispense with a four-room array of heirlooms stored in boxes in all four corners of one room.

So one by one we tackled our "characters." The stars were a pair of spinsters. One was 85, the other 87. We cleaned out boxes from under their beds to the tune of $3,000 in checks, $700 in cash, and three gold pieces. They were so happy with the interest and attention they were shown that they completely furnished a double room on the ward with one of Hill-Rom's blond attractions in memory of their parents.

Results thus far were most gratifying, but not only that, it was a marvelous education. It became the foundation and incentive for starting the service of Geriatrics. In this school of experience, faith, psychology, interpersonal relations, basic human needs, sociology, and politics came into play. It was a trial and error method which has its advantages. The best teachers were our seven "characters," who actually developed into our favorites.

In five months the ward was a different place and—most important—the patients were happy and all under control. The R.N. staff and aides were the best in the hospital, giving top service.

To make our original diagnosis complete, there was one segment of the personnel which was still untreated—namely, the students who still complained that they were wasting time on this division where old people were just waiting to die and no opportunity for their educational advancement presented itself. There must be some way, we thought, to convince them that this was a valuable experience.

As we cleaned rooms and won personalities, a brainstorm took place: Why not geriatric nursing as an educational experience for the student nurses? We were teaching required medical conditions that could not be followed clinically on the ward and the conditions current on the ward were just not in the curriculum. The possibilities were intriguing. We were an educational institution with segregated services and there were four medical services. Why not make one a service for long-stay patients and chronic diseases? It seemed worth a try.

The brainstorm erupted in the offices of the hospital administrator and

director of the school of nursing. They were delighted with the idea and gave their full support. Another clinical instructor took over the medical conditions taught on our ward. We were given four months to study and set up a Geriatrics service. The librarian drew up an annotated bibliography on the subject. The school carried a subscription for *Geriatrics*, the official organ of the American Geriatric Society, and the *Newsletter* of the Commission on Chronic Illness.

With the reading room of the library becoming the "private university" and a host of authors the "professors," the course outline began to take shape in Fundamentals of Geriatrics and Clinical Teaching in Geriatrics.

By June of 1951, we were ready to launch our course in Geriatrics and Chronic Illness. The subject matter covered ten hours of theory and eight hours of clinical class and demonstration at the patient's bedside. The section on theory is divided into eight units.

Unit I Introduction (Here the objectives of the course, vocabulary, basic needs, and statistics are covered)
Unit II Preventive Geriatrics
Unit III Biology of Senescence (normal and abnormal)
Unit IV Rehabilitation
Unit V Social Gerontology (economic and cultural)
Unit VI Psychological Orientation in Geriatrics
Unit VII Organizations
Unit VIII Nursing Care.

There is no text. The students secure their information through lectures, assigned readings and special panel discussions.

The clinical course is concentrated on nursing care of the aged and is divided into four units:

Unit I Patients' histories, oral hygiene, skin care, care of hair, care of the feet, and care of the dead.
Unit II Pre-operative and post-operative care of the elderly surgical patient.
Unit III Cancer
Unit IV Cerebral vascular accident

The school of nursing regularly rotates the students through the department in groups of 8 or 11 for 4 to 6 weeks.

After a five-year period what have been the results? To say that they have been most gratifying is being very mild. Before a year, the State had included the course as a requirement for nurses. The course has gone through three revisions with improvements. The registered nurses, instead of being hard to get for the department, request it upon graduation. One very fine method for testing results has been to have students write a criticism before they leave the department. This method proves to be the source of very good suggestions.

STATE OF MIND

"How old are you?
Age is a quality of mind—
If you have left your dreams behind,
If hope is lost,
If you no longer look ahead,
If your ambition's fires are dead—
Then you are old.
But if from life you take the best,
And if in life you keep the jest,
If love you hold—
No matter how the years go by,
No matter how the birthdays fly.
You are not old!"

The best check has been the patients and their relatives. We achieved the main purpose of the hospital—happy and satisfied patients. The relatives are the publishers of the department and have established a wonderful rapport with the public. We have been called upon to give panel discussions and skits at public gatherings, an excellent opportunity for public education.

One of the finest outcomes has been the contagiousness of the department. For there will be geriatric individuals on all services and to see the principles of geriatric nursing carried out anywhere they are needed, is really an achievement.

The major objective in geriatric nursing being stressed today is preventive. Preventive Geriatrics is fundamentally based upon the basic needs of all human beings, namely:

Affection,
A sense of belonging,
Independence, daughter of Economic Security
Achievement vs. Decline
Recognition vs. Mental Decline
Self-esteem

It takes so little of each to supply so much in the lives of aging individuals. The actual atmosphere of our ward is humidified with these basic needs. Rehabilitation is the keynote.

The patient is admitted with some son of diagnosis. We use that as a spring board to discover the gap in any one or more of these needs. Our nursing care will be steered around meeting these needs. The need for love and attention seems to prevail in all groups. Just knowing someone cares is atomic. We even found that a home permanent will do the trick.* Granny Pam is a good example. Granny Pam came to us with a large open cancer of the cheek. She was a sorry sight with purulent drainage all through her hair and quite belligerent. After a few x-ray treatments and a shampoo, Pam became a different person, but never smiled. We were determined to get a smile from our Granny. We talked over the situation with the family and learned that Pam had not smiled for the past year or so but also we discovered that she had been quite a socialite and proud of her appearance especially of her red hair. That was all we needed.

At our next ward conference we discussed Granny Pam and the students came up with the idea of a home permanent. The family was delighted and gladly secured the home permanent and equipment. We told Pam what we were going to do—just guess what happened, she smiled. Granny Pam continued to smile until she died a year later. Her hair was regularly shampooed and set by the student nurses who all loved her because of her sweet smile.

May be the need will center around a social life. In the beginning we organized social hours on the roof garden but now birthday parties take their place. This is better because the relatives take part and supply the cake and ice cream for the ward, and the hospital supplies the coffee. The daily social life is mainly a trip in the wheelchair around the block or the overhead bridge where the patients have a ringside seat to watch traffic or the ambulance entrance, or read. The TV is no attraction for our oldsters although there are three on the ward. ★

*This brief résumé, I am sure, will convince you that there is much that can be done in the general hospital for our aging citizens. It is not a dead-end street but a field wide open for education and the rendition of life and hope to our most worthy oldsters. We as members of Catholic hospitals should be leaders in this—will you not agree?

BRITISH WAYS IN AGED CARE

Pioneer Advances in Architecture, Décor and Spirit of Treatment Give Britain's Old Folks a New, Cheerful Lease on Life

Three elderly residents of a Rest Home in London, England, make an amicable group as they take the air and sun outside the vine-bordered, arched doorway to the garden.

The ramp which has replaced the front steps at Westmoor, a "half-way house in London. Besides purposes of exit and adit, the ramp is used for safely exercising patients.

Three residents of Westmoor help with domestic work in the kitchen, showing that even deformed hands can be useful when there is the will to help. Westmoor, founded on a grant from King Edward's Hospital Fund for London, is called Half-Way House because it provides a transitional residence for sufferers from chronic ailments who have been discharged from the hospital and have no place to go, until further arrangements are made.

THERE'S NOTHING "INSTITUTIONAL" about tea in the dining room of this Rest Home in London. The tables, seating just four, provide a more intimate atmosphere than the refectory type; they are set against a cheerful background of gaily-patterned draperies, cut flowers and potted plants.

WHATEVER ELSE may be said about the "welfare state" of the British type, there can be no doubt that it has bettered immensely the twilight years of the aged there.

Great Britain has been—along with Sweden, Denmark and Switzerland—a leader in the early evolution of geriatric facilities and gerontological studies. These changes, however, would be relatively empty gestures, were they not motivated and maintained by a new spirit, a new way of looking at "senior citizens" (or "subjects"). This renaissance in viewpoint has brought about a re-evaluation of the status of the elderly, and a re-examination of their value to society.

Happily, signs in the United States and Canada point to the developing of a comparable "climate of opinion" here. ★

TENANT of a Churchill House relaxes in comfort. The oldster above has a sense of security heightened by the satisfaction of being surrounded by her own possessions, since all the furniture and bric-a-brac belong to her.

AN ELDERLY COUPLE (right) put their enjoyment of a fine day to good use by getting in a bit of gardening and tidying up the grounds of the Half-Way House which is their temporary residence.

The Inter-relationship of Diet & Longevity and Between Nutrition & Chronic Illness

The idea that diet is related to longevity and nutritional status to chronic disease is not new. Adelia Beeuwkes[1] in her review points out that Hippocrates supported the relationship. Roger Bacon (1214-1294), Thomas Elyot (1499-1546) and Francis Bacon (1561-1626) wrote essays on the subject. In 1881, Charcot published his "Clinical Lectures on Senile and Chronic Diseases" which placed emphasis on physiology rather than philosophical observations. In her review, Beeuwkes points out that "in 1909, I. L. Nascher suggested the term 'geriatrics' to cover a special branch of medicine dealing with old age and the diseases of the aged. In 1914, Nascher published the first textbook devoted in its entirety to geriatrics...It was the only textbook of its kind and opened the way to progress in this field."

—The Authors

Nutritional Status of the Aging

by H. D. CHOPE, M.D., DR. P.H., Director, Department of Public Health and Welfare, San Mateo, Calif.

and LESTER BRESLOW, M.D., M.P.H., Chief, Bureau of Chronic Diseases, State Department of Public Health, Berkeley, Calif.

AS EACH DECADE PASSES, it becomes more and more important that clinical and preventive medicine develop a deeper and more scientific understanding of the underlying etiological factors involved in the chronic diseases. Brightman[2] presents a table predicting the percentage distribution of the population in the United States.

Shifts in Age of Population of the United States

Year	Life Expectancy	Proportion of Population Over 45 years	Over 65 years
		%	%
1900	48	17	4
1950	67	28	7
1980 (predicted)		40	10

Although there has been an increase in life expectancy in all age groups, the really dramatic increase has been in the very young. The expectancy of a person at age 60 is very little more today than it was 50 years ago.[3] The five leading causes of death have shifted from the infectious diseases to the chronic diseases. "Aging need not be synonymous with degeneration."[4] Neither is it sufficient just to prolong life in our modern concept of health. Johann Heinrich Cohausen (1665-1750) reminds us "Some misguided enthusiasts have believed that by lengthening life they would confer a priceless boon on the human race; forgetting that it is not the length of the day which makes us love the summer, but the brightness of the sun, the beauty of the flowers, the singing of the birds" (Ibid. (1)). Certainly, it may be hoped that, as new scientific facts are gathered, people may not only lead a longer but also a more functionally active and socially useful life. Doctor Walter L. Palmer[5] has expanded this thought in his chairman's address to the Section on Internal Medicine of the American Medical Association.

The study reported here represents an effort to add a "few more small stones" to the edifice of knowledge regarding nutrition and aging which is now abuilding. It was a joint endeavor by the: (1) the U. S. Bureau of Human Nutrition and Home Economics, (2) the United States Public Health Service, (3) the department of Home Economics of the College of Agriculture of the University of California, (4) the California State Department of Public Health, (5) the San Mateo County Department of Public Health and Welfare; and (6) the San Mateo County Medical Society. The basic study was carried on during the summer and fall of 1948 and early 1949, when 577 volunteer subjects over the age of fifty and apparently healthy were examined. The criteria for selection from 843 registrants were:

Health. Not on a special diet, not under the care of a physician within the previous three months, physically and mentally capable of participating, and subjectively in good health.

An equal sample of males and females—the final count was 280 males and 297 females.

An age distribution from 50 to 90 years, the final distribution being as follows:

Age Group (Years)	Number	Percentage of Total
50-59	192	33.2
60-69	215	37.3
70-79	137	23.8
80-89	33	5.7

A sample form from all economic groups, the final distribution being:

Low economic	106	18.4%
Middle economic	445	77.1%
High economic	24	4.2%
Unknown	2	.3%

This paper, presented before the convention of the American Public Health Association in Kansas City, Mo., on Nov. 18, 1955, is used by permission of the authors and of the American Journal of Public Health, in which it is appearing simultaneously.

Of the 106 low economic group, 47 were in a county institution for the aged and 59 were living in the community on small pensions or Old Age Assistance.

The investigation consisted of four parts.

1. Nutritional history including: a) seven-day recorded food intake; b) general food history taken by nutritionist

2. Clinical history including: general medical history and detailed systems history

3. Physical examination

4. Laboratory procedures including blood (hemoglobin, serum protein, sedimentation rate, packed red cell volume, blood glucose, ascorbic acid, Vitamin A, carotene, non-protein nitrogen free cholesterol, cholesterol total, leukocyte count with cell differential, erythrocyte count and serological test for syphilis); urine—glucose albumin, chest x-ray, bone density determination (Method of Dr. P. B. Mack); and vaginal Papanicolaou smears for all female patients.

The results of the laboratory and nutritional studies on this group have been reported by Morgan, Gillum and associates of the Department of Home Economics, of the College of Agriculture, University of California.[6, 7, 8, 9, 10, 11] These six papers with a combined bibliography of 129 references provide an excellent review of the current knowledge and the findings of these studies.

With such a large volume of detailed data available on the subjects of the 1948 study, it appeared that "longitudinal studies" or repeated examinations of the same subjects, might offer additional useful information. Therefore, in the summer of 1952 as many as possible (350) were re-examined using a somewhat less complex procedure.[12, 13] Again, in the spring of 1955, a second follow-up was done on these subjects. The complete analysis of the data is not yet available, but certain relationships between nutritional status and health can be explored from the existing information.

Deaths

In the seven-year period, 1948 through 1954, eighty-eight, or 15.3% of the 577 subjects had died. Of these sixty-three were males and twenty-five were females, giving a percentage death rate of 22.5 and 8.4 respectively. These deaths are shown classified into broad class according to the International Causes of death in Table I.

Although this series is very small, it confirms what has been pointed out many times:

The three major categories, heart and circulatory diseases, nervous system disease, and malignant neoplasms, account for 85% of the deaths to date in this group of individuals over 50 years of age.

Heart and other circulatory disease are the greatest killers of all of the diseases.

The death rate in this series from heart and circulatory diseases is three and one-half times greater in men than in women.

The death rate from heart and circulatory diseases is five times greater in those over 70 than in those 50 to 69 years of age.

The death rate from nervous system disease is about equal in men and women, but two and one-half times greater in those over 70 than in those 50 to 69.

In this series, to date the death rate from malignant neoplasms is three times higher in males than in females, but about equal for the two age groups.

TABLE I

DEATHS BY SELECTED CAUSES SEX & AGE 1948-1954

		SEX		AGE	
	Total	Males	Females	50-69	70+
TOTAL IN GROUP	577	280	297	406	171
Deaths	88	63	25	35	53
Deaths/1000	152.5	225.0	84.2	86.2	309.9
Cause of Deaths by Group and I.C.S. List Numbers:					
Heart & Circulatory (400-468)	83.2	132.2	37.0	36.9	193.0
Nervous System (330-398)	20.8	21.4	20.2	14.8	35.1
Malignant Neoplasms (140-205)	26.0	39.3	13.5	24.6	29.2
Respiratory (420-527)	6.9	10.7	3.4	2.5	17.5
All Other Causes	15.6	21.4	10.1	7.4	35.1

The respiratory system death rate is three times higher in males than in females and seven times higher in those over 70 than in those 50 to 69 years of age.

Since heart and circulatory diseases are responsible for 54% of all deaths in the total universe studied and 58% of the male deaths and 62% of the deaths over 70 years of age, it would appear that the exploration of any relationships between nutrition and heart disease would be worth study.

Hypertension

High blood pressure is commonly associated clinically with cardiac failure and death. Table II shows that the percentage of deaths in the total series was four times higher in the patients with recorded (1948) systolic pressures over 180 mm. of mercury than in those with systolic pressures of less than 140. In males the percentage of deaths was four and a half times higher in the hypertensive groups than in those with systolic pressures under 140. However, in women the percentage of deaths was only one and a half times greater.

Table II also records the diastolic pressures. Apparently diastolic pressures over 100 mm. of mercury are not correlated with cardiac deaths to the same degree as systolic pressures over 180 mm. of mercury. However, the death rates were slightly higher in those patients with diastolic pressures over 100 as compared with those with diastolic pressures under 90 mm. of mercury.

TABLE II

DEATHS BY SEX IN RELATION TO SYSTOLIC AND DIASTOLIC BLOOD PRESSURE—(1948-1954)

	Total			Males			Females		
	No. Examined in 1948	Deaths No.	Deaths %	No. Examined in 1948	Deaths No.	Deaths %	No. Examined in 1948	Deaths No.	Deaths %
TOTAL	577	88	15.3	280	63	22.5	297	25	8.4
Systolic Pressure									
Less than 140	115	11	9.6	67	6	9.0	48	5	10.4
140-179	300	35	11.7	148	30	20.3	152	5	3.3
180 & over	161	42	26.1	65	27	41.5	96	15	15.6
Unknown	1	—	—	—	—	—	1	—	—
Diastolic Pressure									
Less than 90	197	27	13.7	105	19	18.1	92	8	8.7
90-99	202	27	13.4	98	21	21.4	104	6	5.8
100 & over	178	34	19.1	77	23	29.9	101	11	10.9

Obesity and cardio-vascular disease and cardiac deaths are frequently related. Armstrong, Dublin, Wheatley and Marks[14] published a review of the statistics and an analysis of an insured group stating that at least one-fifth of the population of the United States is overweight. Our series of individuals over 50 years of age show 85, one-seventh of the group, to be 16% or more overweight, somewhat less than the one-fifth cited by Armstrong. However, the relationship between overweight and cardio-vascular deaths is clearly borne out by Table III. This table shows that while the percentage death rates for all other causes are roughly constant in all three weight groups, those individuals 16% overweight have a death rate from cardio-vascular-renal disease nearly double that of individuals in the average weight group.

Cholesterol intake has also been related to hypertension and arteriosclerosis. Gillum et al[9] have reported from this same series of data that serum cholesterol for men was 241±8 and for women 270±8. It is pointed out that these differences cannot be ascribed to food intake since the intakes by men of cholesterol, fat and protein, all of which were found to exert some positive effect upon the serum cholesterol, were equal to or greater than those of the women studied. These same investigators found a correlation between high serum cholesterol levels (over 260) and overweight in men, but not in women.

Our data fails to sustain a relationship between high serum cholesterol and hypertension or cardio-vascular-renal deaths (Table IV). In fact, the reverse seemed true, those subjects with the lower blood cholesterol levels suffered the highest death rates from cardio-vascular-renal disease. Analysis of this relationship in two age groups—those under seventy years of age and those seventy years or older—disclosed that mortality in the former group did not vary with the cholesterol level; among persons seventy and over the higher the cholesterol the lower was the mortality.

Vitamins and Mortality

A suggestive relationship was found between mortality and the blood levels of vitamin A, niacin and ascorbic acid, as shown in Table V. The death rates in individuals with a low blood concentration of each, and of all these three vitamin factors, was higher than in those subjects with normal or high blood concentrations.

No significant relationship could be found between mortality and any of the following factors determined for the volunteer subjects: hemoglobin, blood glucose, blood creatinine, caloric intake, protein intake, fat intake, carbohydrate intake, calcium or iron intake.

The objective of any preventive program is not only to prolong life, but to try to make life as effective and useful as possible and, in older people, as comfortable as possible. Doctor Joseph H. Sheldon has stated that life is much fuller for aging people if four functions can be preserved or restored—ambulation, hearing, vision and mastication. Our study provides data on one of these functions, mastication. Table VI shows the number of teeth remaining in the mouths of the subjects examined by economic groups.

The high percentage of edentulous subjects in the low economic group, as compared with the high economic group, may perhaps be explained by both poor diet and inadequate dental care in the low economic group. In a previous paper[12] a very high correlation between economic status and blood ascorbic acid content was demonstrated.

TABLE III

Deaths Related to 1948 Overweight

	Total in Group	DEATHS: All Causes		Cardio-Vascular Renal		All Other Causes	
		#	%	#	%	#	%
16% Overweight	85	16	18.8	13	15.3	3	3.5
Average Weight	387	52	13.4	33	8.5	19	4.9
16% Underweight	93	13	14.0	9	9.7	4	4.3
Unknown	12	7	—	6	—	1	—
TOTAL	577	88	15.3	61	10.6	27	4.7

TABLE IV

Total Cholesterol Related to Deaths

	Total in Group	DEATHS: All Causes		Cardio-Vascular Renal		All Other Causes	
		#	%	#	%	%	#
Mgm/100 ml. Blood							
Less than 220	145	38	26.2	22	15.2	16	11.0
220-279	276	34	12.3	25	9.1	9	3.3
280 & Over	148	13	8.8	11	7.4	2	1.4
Not determined	▮	3	37.5	3	37.5	—	—
TOTAL	577	88	15.3	61	10.6	27	4.7

TABLE V

Blood Levels of Vitamin A, Niacin and Ascorbic Acid, and Mortality

	Subjects	Deaths	Rate
Vitamin A (International Units)			
Less than 5000	158	34	21.5
5000 - 7,999	160	25	15.6
8000 and over	211	21	9.9
Not determined	48	8	—
Niacin (mgm.)			
Less than 10	154	29	18.8
10 - 13	196	33	16.8
14 and over	179	18	10.1
Not determined	48	8	—
Ascorbic Acid (mgm.)			
Less than 50	130	36	27.7
50 - 109	251	26	10.4
110 and over	148	18	12.2
Undetermined	48	8	—
	577	88	15.3

TABLE VI

Relation of Remaining Teeth to Economic Level

Number of Teeth Present	*Total* #	*Total* %	Economic Group: Low #	Low %	Middle #	Middle %	High #	High %
None	221	38.3	54	51.0	164	36.9	1	4.2
1 - 6	117	20.3	25	23.6	86	19.3	6	25.0
10-28	237	41.1	27	25.4	193	43.4	17	70.8
Unknown	2	.3	—	—	2	.4	—	—
	577	100%	106	100%	445	100%	24	100%

Morgan[8] has demonstrated a relationship between blood, ascorbic acid and number of teeth. Those subjects having ascorbic serum levels of less than 50 mgm were 50% edentulous, subjects with 50-109 mgm were 40% edentulous while only 32.3% of those with 110 mgm of ascorbic acid

(Concluded on page 70)

"The problem of the aged affects us collectively as members of a society whose population is growing older. It affects us individually as we plan for our own future and accept or reject the responsibility of contributing time, love and money to the welfare of family and friends. The burden of decision cannot be transferred to an employer, a union or a government agency."—John J. Corson and John W. McConnell, in *Economic Needs of Older People.*

Medical Documentary on Care of Aged Premiered at New York Academy of Medicine

PROOF THAT PROLONGED INACTIVITY, particularly bed rest, is often the greatest enemy of health in advanced old age is offered by two New York physicians in a medical documentary film premiered last month at the New York Academy of Medicine.

Titled "Still Going Places! Active Management of Disability in the Aged," the 40-minute documentary, written and directed by George C. Stoney has been designed as a teaching film for medical and nursing audiences.

The film's emphasis on practical ways to help more old people preserve their ability to care for themselves has created widespread interest among representatives of social welfare and civic groups who are struggling with the ever-growing problem of providing daily care for hundreds of thousands of elderly invalids.

The film shows one 88-year-old woman beginning to walk independently again 12 weeks after she broke her hip. An 84-year-old double amputee demonstrates his skill in walking with two artificial legs.

The same principles of active management are recommended for many elderly patients suffering from chronic diseases. A 93-year-old great-great-grandmother is shown keeping house and doing her own shopping on busy New York streets despite a half-dozen chronic infirmities including widespread hardening of the arteries.

"Once this kind of help is made available in every community hospital and through private physicians, fewer aged people with normal capacity for recovery will need long-term institutional care for medical reasons."

"Still Going Places! Active Management of Disability in the Aged" will be available for showings to physicians upon request from the Film Library, Pfizer Laboratories Division of Chas. Pfizer & Co., Inc. 630 Flushing Avenue, Brooklyn 6, New York, which provided the grant to finance the picture. ★

(Boston Traveler Staff Photo by Anthony Cabral)

PRINCE of the Catholic Church, India's Valerian Cardinal Gracias (fourth from left), and Archbishop Richard J. Cushing (third from left), who appeared at regional conference on Hospital Accreditation and Patient Care at Hotel Statler, sponsored by The Catholic Hospital Association. . . left to right: Dr. Anthony J. J. Rourke, New Rochelle, N. Y.; Rev. John J. Flanagan, director, Catholic Hospital Association; Archbishop Cushing; Cardinal Gracias; Rt. Rev. Donald A. McGowan, National Catholic Welfare Conference, and Charles E. Berry of St. Louis University School of Hospital Administration.

St. Expeditus Hospital

Dear Sister Michaeleen:

You certainly looked fine Christmas week. Hospital food must agree with you. But watch that waistline. Our Sister Henrica is on one of those egg and grapefruit diets now and is doing O.K. I think all the nuts and candy that were around the nurses' stations over the holidays must have gotten her down. In her case it was either diet or get some new uniforms. And don't tell me nuns aren't sensitive about people kidding them about their avoirdupois. I know. I tried it once.

We are still quite liturgical here. The Christmas crib in the chapel was kept until the octave of the Epiphany. I also blessed chalk on that day and inscribed the C.M.B.-1956 on the doors of the chapel, the nuns' dining room and the school of nursing.

By the way, you would be interested in a report I received the other day. It's a summary of a questionnaire of student nurse opinion at one of the other schools of nursing in the Diocese which has about 120 students, 80 Catholic and 40 non-Catholic. The questions were patterned after those asked the University of Notre Dame students in their annual religious survey. No names were required--just the class, religion and, if Catholic, whether they were frequent communicants.

The girls were told to answer the questions frankly and from all indications, believe me, they did. The questions dealt with attitudes on nursing, study time, social life, relations with patients, nuns and teachers, what student nurses talked about, plans for the future, discipline, floor management, facilities for confession, guidance, and attendance at Mass and other services.

Some thought the religion classes were impractical. They seemed to want more discussion time on problems that come up on the wards and problems dealing with marriage.

In the section dealing with personnel relations, the great majority were in favor of nun supervisors, if they were fair. A few were quite critical of nuns who consciously or unconsciously played favorites. Some criticism was offered lay supervisors or head nurses who spent too much time at the chart desk, and who were scared to make decisions when the time came.

A number of the non-Catholic students thought Catholic students were "cliquey" and had a "we've got it made" complex. A great number of the Catholic students thought that the students weren't taken into consideration when chapel services (outside of Mass) were arranged. Some of these also expressed the desire to go around with the chaplain on Communion rounds and the formation of a nurses' choir or at least the opportunity to sing with the nuns when High Masses were offered in the chapel. Students who had gone to Catholic high schools in the Diocese said they missed the Dialogue Mass. Everybody liked the annual retreat, but thought more sermons were needed to point up ways of sanctifying their nursing during the rest of the year. The great majority are planning to get married after graduation and when the right man comes along.

Gee! I just forgot. My Blue Cross is due today. Write soon. In Christ through Mary.

Father Brian

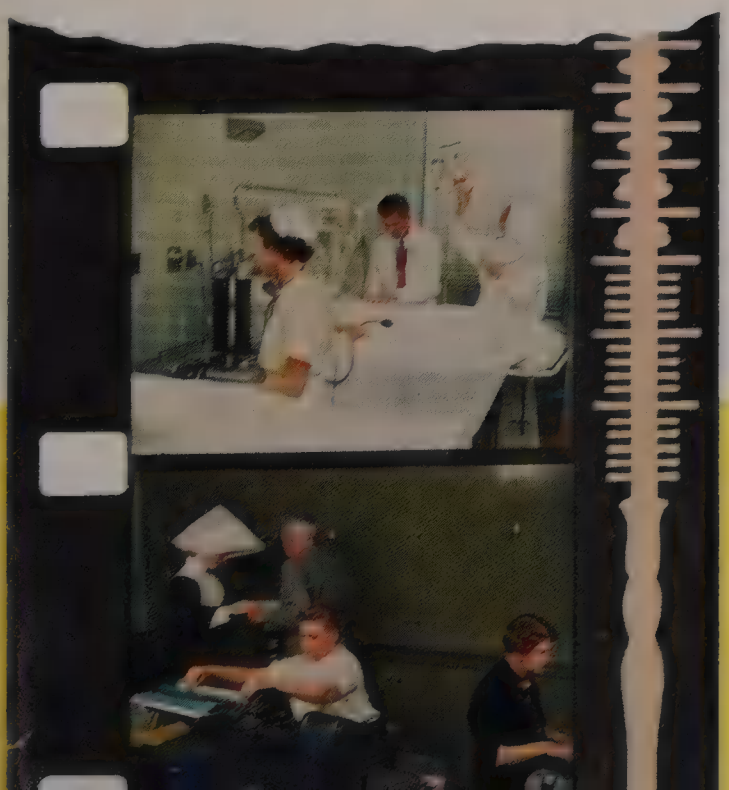
Presenting...

AND ANNOUNCING THE AVAILABILITY OF

Title panel *(right)* of the 16mm documentary in full color, with sound narrative and musical score. Running time is 28 minutes.

Starring...

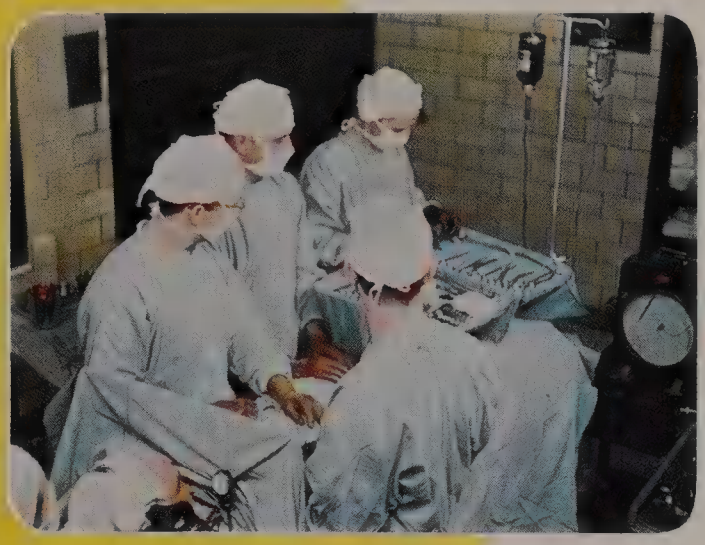
ALL CATHOLIC HOSPITALS

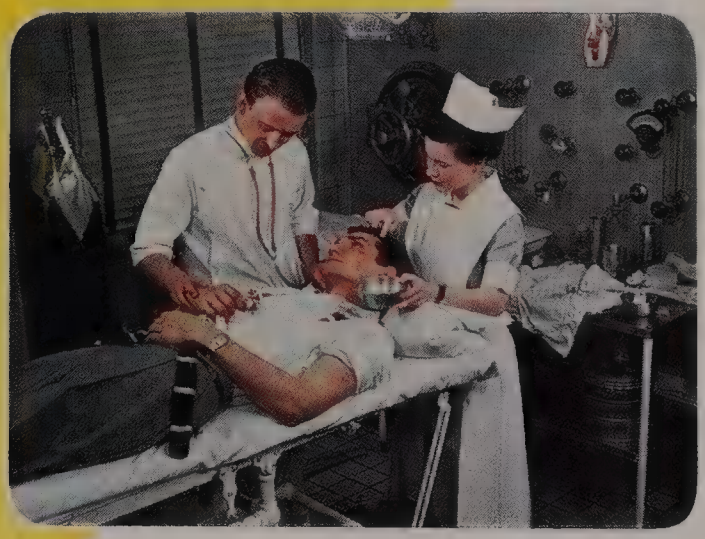


Featuring...

- ☆ Role of Religious Orders
- ☆ Medical Advances
- ☆ Nursing Education
- ☆ Work of Lay Personnel

The Most Advanced Techniques of Modern Medical Science and Paramedical Care Are Shown "At Home" in Catholic Hospitals





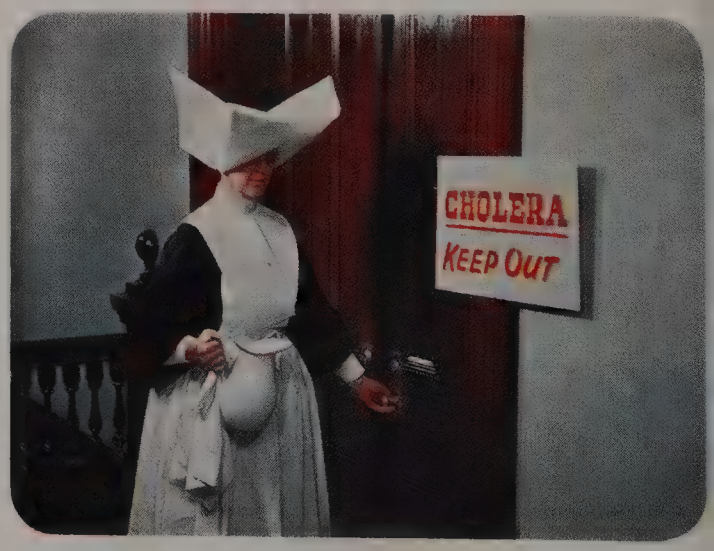
A cinematic triumph is achieved in *The Dedicated,* first and—thus far—only film devoted to the history, background, philosophy and work of Catholic hospitals.

The film, sponsored by The Catholic Hospital Association, appears in the glorious color of the Kodachrome process.

Photographed by the experienced personnel of Chulack Productions, of St. Louis, its vivid scenes are supplemented by an effective sound track. The script is credited to James Dutson and is narrated by Marvin Miller, well known in radio and TV work.

Another achievement lies in making prints of the movie generally available. Now individual hospitals, Religious Orders and civic groups can obtain a copy—either by outright purchase or on a rental basis—for a multitude of uses.

Dramatic Historical Review Depicts the Church's Age-Old Mission of Tending the Sick Both Spiritually and Physically



HOW THE FILM CAN BENEFIT *You*

Some of the many important ways in which *The Dedicated* can aid hospitals in formulating or forwarding vital projects are:

● COMMUNITY RELATIONS

The film will familiarize the people of any area with the basic philosophy of the Catholic hospital, the scope of its services, as well as the integration of modern medical science into the age-old concept of care for the ill and needy.

The movie is a striking and memorable center for such occasions as anniversary celebrations, National Hospital Week observances, etc.

It also explains (indirectly, of course) why costs that seem high to the average person are only just, in view of the variety and "depth" of the services available and rendered.

● RECRUITMENT

Religious Vocations . . . Nurses . . . Technicians . . . Other Personnel.

● IN-SERVICE TRAINING

No better means is available for the orientation of new employees, and for their integration into both the intra- and inter-departmental spirit of co-operation that enables a hospital to function.

● MEDICAL STAFF-ADMINISTRATION RAPPORT

The Dedicated emphasizes the role of the physician and surgeon in the present-day hospital, to demonstrate that without them any hospital is an institutional shell.

Administration is not all there is to a hospital—nor is medical practice. The necessary co-ordination of their methods and aims is a much-to-be-desired result of the film.

● FUND RAISING

Since almost every hospital has problems of replacing equipment, installing new apparatus, expanding departmental areas, etc., the film has a valuable function in explaining the need for keeping physical facilities abreast of medical advances, as well as maintaining them at levels consonant with hospital accreditation and certification as agencies of medical education.

It is, of course, feasible for many hospitals to acquire this film on their individual administrative cognizance.

The suggestion may be made also that obtaining the film would be a constructive and praiseworthy activity for such groups as the following:

- Guilds and Auxiliaries
- Lay Advisory Boards
- Community Groups—Holy Name Societies, Women's Clubs, the Chamber of Commerce, etc.
- Mother Houses—which could rotate a print through different Communities
- Regional Conferences of Catholic Hospitals

Details regarding purchasing and rental can be obtained by writing to "The Dedicated," c/o The Catholic Hospital Association, Dept. H-12, 1438 South Grand Blvd., St. Louis 4, Mo.

ECCLESIASTICAL AND LAY APPROBATION

Allow me to express my deep satisfaction with the film portraying the work of the Catholic Hospital Association.

The place of the Catholic Hospital in the community, the history and growth of hospital work under Catholic auspices, the up-to-the-minute technical efficiency of the modern hospital, the delicate insinuation of the missionary spirit, and above all the portrayal of the motivating force underlying the galaxy of Catholic Hospitals in the United States and Canada—all reveal why the film has been correctly entitled "The Dedicated."

This wonderful film should help the cause of Catholic Hospital progress and make the public aware of a service that for the most part has been hidden.

✠ CHARLES H. HELMSING
Auxiliary Bishop of Saint Louis

THE CATHOLIC HOSPITAL ASSOCIATION OF THE UNITED STATES AND CANADA

. . . a most inspiring film. I can easily appreciate the tremendous amount of research which must have been done to produce it. I was most impressed at the manner in which the spiritual thread was maintained throughout the picture. The medical and hospital material was handled in excellent taste.

I would like to make the observation that this film could well be shown in every Catholic High School, and it would prove of great value in recruiting lay hospital personnel, and more important, it would inspire the young people of today to consider a religious vocation in the hospital field. . . . a source of instruction as well as inspiration.

"The Dedicated" is an excellent example of our ability to see the face of Christ in the sick and the poor. Such an apostolate is beyond our ability to measure.

✠ LEO C. BYRNE
Auxiliary Bishop of Saint Louis

Recording the history and achievements of our Catholic hospitals in the United States and Canada over the past forty years presented a tremendous challenge which has been met in an admirable manner by the film, "The Dedicated."

All Religious Communities would find it worthwhile to own a print of this film. Not only will it give inspiration and renewed enthusiasm to their own members, and hospital staffs, but information and enlightenment to lay boards of men and women and to the public in the community in which they labor. It might well serve also as an effective medium for the promotion of vocations through showing to high school and college groups in Career day programs.

SISTER LORETTO BERNARD
Administrator, St. Vincent's Hospital
New York City, N. Y.

During the past few weeks I have had the pleasure of previewing the film, "The Dedicated," in which I had the opportunity of participating in the planning and filming. . . . an excellent portrayal of the magnificent work of the religious through the years in behalf of those less fortunate. I was especially pleased with the technical aspects of the film in that it adhered to an accurate scientific portrayal of the subject matter.

JAMES P. MURPHY, M.D.
St. Louis, Mo.

Social Life and Recreation in Homes for the Aged

Knowledge of "play psychology" can help personnel arouse the "will to live" in their elderly charges

by ANTHONY SALAMONE, Director, Adult Education Center ● Saint Louis University

APPROXIMATELY four to six per cent of U.S. adults, aged 65 and over, presently reside in "Nursing Homes" or "Homes for the Aged." Although this does not sound like a very large percentage, it assumes great significance in terms of numbers, for upwards of 500,000 may be living in various congregate centers. Nursing homes and homes for the aged therefore are indeed important among installations for specific adult community age groups. What they offer—and how they offer it—have a real effect upon community planning and attitudes toward the aged.

A nursing home or home for the aged is usually described as a type of living arrangement so designed as to house and offer personal assurance and care to a substantial number of older people. The needs of these people for physical and social care, in turn, usually vary greatly. As a group, these persons may be much older than the members of a Golden Age Club or a Senior Citizen's Center, for within the past 25 years the average age of residents has risen from about 65 years of age to upwards of 77 years.

Paradoxically, while homes for the aged and nursing homes have greatly increased during these years, it is still only within a handful of years that a general awareness has developed around the primacy of the social and recreational atmosphere in these institutions. Most of these homes do not have a social service department or a recreational worker, nor anyone assigned especially to these very vital roles. Most homes are only interested in the medical or physical care of the aged, forgetting or unconsciously neglecting the psychological and sociological aspects of the older person.

The moment the older person is brought into the nursing home by a member of his family or when, in many cases, the older person applies voluntarily for admittance at the suggestion of the family, that person has already developed a mental attitude of being unneeded and unwanted, not only by society, but by those whom he thought were his dearest ones.

To be needed and loved are basic needs of all people of all ages, but many older people are living daily lives of acute frustration and loneliness long before they enter a nursing home. Having lived alone, or with their families, where the question often came up as to "Who is going to take care of Pa or Ma, Grandpa or Grandma, if they become ill?" made them feel out of the stream of things. They began then to lose their sense of belonging.

Believing that they have lost their purpose of existence, many recede frequently and early into unnecessary deterioration, or they compensate with a variety of provoking and irritating defenses—cantankerous conduct boastfulness and bragging, domineering behavior, or comparable reactions. These mental "sets" and attitudes develop to such an extent that before the older person is admitted to the nursing home, he has to some extent developed progressive deterioration of the brain cells which eventually will lead to senile psychosis.

Still another thing that helps to develop attitudes of being unloved and unwanted when one is going voluntarily (or subconsciously not voluntarily) to a nursing home or home for the aged are the names to be found for such homes in the United States, such as: "Home for Friendless Women," "Home for Intemperate Men," "Home for Deserving Old Ladies," "Home for Respectable, Aged Indigent Females," "Home for Incurables"—there are even "Homes for the Homeless!"

Although not universally recognized nor practiced as such, the nursing home and the home for the aged is rapidly emerging as a social agency with positive, desirable standards of care. Originally interpersonal relationships were possible only for the select few who had visitors or some one in the home to visit. Plans to insure interaction among the aged residents much too often have been completely neglected.

A new era, however, is beginning to change this picture. The usual type of domiciliary care available to the aged in the past is gradually being discarded. The new concept of service now, is to take into account the social and psychological aspects of human behavior. Certainly, to most old people, it is an extreme break with the past when they come to live in a congregate manner. To alleviate or forestall the trauma of such a break, in order at the same time to open the doors to continued pleasant living is a basic challenge to all nursing homes.

If a social atmosphere is to be cordial, effective and warm, the specific social and recreational needs of the resident (which are more keenly felt by old adults, and perhaps less verbalized by them as a group, than by people of other ages) must be taken into account. These needs include opportunities toward stimulating the basic desire to learn, to maintain and develop status, retain or renew old skills and develop new ones, and (perhaps the most important) to create the feeling of being wanted through companionship and enjoyable outlets. Positive and stimulating relations are particularly dependent upon the home environment of which they are a part.

Too often, the concept of "home" is left out of "Home for the Aged" or "Nursing Home." Since I am limited here to the topic of "recreation," I'm not going to dwell on the other factors needed to make a nursing home or home for the aged a *home;* but what I have said up to now points out the irritations that demand trying adjustments at a time when resilience is low.

Since recreation is a basic human need, a specialist in improving individual relationships and group consciousness is now regarded as a factor in "home" life as are the other services. However, the provision of a social worker, recreation leader or therapist within a home staff does not in itself insure a more satisfying life to the residents, for the quality of such a service is derived not only through the procedures which are used, but also the manner by which these skills are used. A professional worker must be a warm person who respects old adults and is accepted by the residents and the fellow staff members. A skilled and capable worker is indeed a derivative of wise administration.

Mrs. T., 83 years old, was very suspicious of everyone who performed any kind of service in the Home for the Aged where she lived. She was unkempt in appearance and saw no reason for being tidy. "After all, I'm not going anywhere," was her usual comment. Six months after a patient volunteer with great perseverance began to 'work' *with* her—under the direction of a trained social organizer—Mrs. T. demonstrated her social development with her statement that the volunteer's 'pin was not becoming to her.' At 84 Mrs. T. regained her interest in personal appearance and is eager to participate in most of the functions of the home. No longer does she remain aloof from group activity. Neither does she consistently and adversely criticize her neighbors and the staff. With much energy and care she selects her clothing and those social outlets which interest her.

Mrs. Z., a 67-year-old patient in a mental hospital, was released to a Home for the Aged. There was no organized social service and the administrator acted in a maternal role toward the residents. A personality clash arose between the two, and although the former expressed her desire to live in a more normal environment such as that represented by the Home, and even though she was not a detriment to the other old people nor the functioning efficiency of the Home, she was returned to the hospital. The lack of a sensitive understanding staff member and board forced Mrs. Z. back into an environment which stultified her. Oblivion and mere existence followed.

These examples, only two of the countless situations which arise, both illustrate the extreme importance of competent, perceptive social direction.

Programs

The types of programs designed to make life more satisfying to older adults will vary from institution to institution. In any event, group morale has its greatest enhancement when the old people themselves have a voice in any planning which affects them. Means of making this possible may differ, but one effective technique is a resident's council. A newsletter, suggestion box, periodic gatherings with the administrator, are illustrative of other ways.

The program must take into account the emotional requirements of people and those environmental factors which are particularly associated with older people. The many years of community living by the residents should not be disregarded. Therefore, even before actual activity is begun, an over-all, truly comprehensive policy should be delineated, for no home can operate in isolation without regard for community structure.

Maintenance of independence and self-respect is a most important goal of any social program. Over-protection of the elderly is as dangerous to their well-being as complete indifference to their special requirements. For example, paranoia may be enhanced when constant rebuffs are felt and previously normal outlets are frustrated. The "No Smoking" rule and "Don't do this and don't do that" rules are frequently by-products of overprotection. On the other hand, when no solicitude is shown, apathy and rebellion are fostered.

In either event, both approaches may push the old person into a state of abnormal aging which is usually described by the general term, "senility." To delay or prevent this disinterestedness and apathy which results in a rather complete retreat inward and away from the surrounding world, and to promote well-being, is another expressed aim of social life.

"Doc" Eberhardt, director of Physical Education at Saint Louis University, once said, "We don't stop playing because we grow old; we grow old because we stop playing." Recreation has been described as "Finding joy in living." Experience shows that recreation *can* bring greater joy in living to the older person, regardless of his or her situation; but recreation is a very individual matter. The kind of activity that satisfies one individual may bore another. Fortunately, the variety of possible recreational activities are almost endless.

It is necessary in developing recreational activities that these programs provide opportunities for: (1) Companionship, (2) Fun, (3) A sense of belonging, (4) Developing new interests and skills, (5) Retaining or renewing old skills, (6) Stimulating the desire to learn, (7) Continuation of curiosity, (8) Adjusting to a change of environment, (9) Maintenance or development of status, and (10) Feelings of being needed, and of usefulness.

These needs are the same needs that we all have, regardless of our age or where we are, but they have attained greater importance for the older age group as their opportunities for social communication have diminished. Each of the aforementioned service areas is related to a healthy philosophy of living by promoting a feeling of contentment and achievement by the older person. Mental well-being is related to outlets for companionship or usefulness or creativity.

More and more we are recognizing that our modern civilization with its complex, changing cultures plays an exceedingly important role in the etiology of mental illness. This can usually be traced to a lack of individual worth and dignity which invariably is derived through some type of social group. The use of this type of group on behalf of the senescent and the senile, the normal and the psychotic began only a handful of years ago.

The basic principle of doing "with" people is *never* compromised, although it may be modified to a degree depending upon the functional capacity of the old. In this respect, the importance of psycho-social factors should not be underestimated. Over-rapid senescence, which leads toward senility or degenerative diseases, may be controlled in some instances

by an environment in which older people could meet their own needs in their own way. And is that not the major goal of recreation and education? Consequently, recreation may be described as anything which provides satisfaction. Education, in turn, is concerned primarily with those studies which will provide the old adult with the opportunity to live to the maximum of his abilities.

Again, the relation between teacher and student, leader and member, should be one of active sharing. Emphasis, then, is upon free and open expression under the guidance of skilled teachers, group workers or member-leaders.

It follows, then, that it is not merely opportunities that should become available, but opportunities of the highest quality.

Some people have never learned how to play. Others created only "on the job" or "for the family."

Implicit throughout is the importance of social contacts for mental well-being through continued or revived or even newly developed contributions; in this case, either to self or self—and—others. They may serve as a supplement and/or substitute for family and vocation. Too, the interests and leadership of aged persons should be encouraged in the planning and development of any resources of which they are a part.

The leaders' aims in organizing the program should be to:

1. Meet the particular needs of the *individuals* in the group;
2. Make as much as possible of the capacities of each *person* and the *group* as an entity;
3. Discover the *goals* common to members of the group so they may move together toward reaching them; and
4. Assist the group to become more conscious of social responsibility—this, in addition to or distinct from, individual social responsibility.

The satisfactory living arrangement eagerly sought by every resident or patient is highly dependent upon the interactions of the individuals within the group. As outlined earlier, educational-recreational goals are intimately linked with the interactions of old adults to other old adults and to the group worker or teacher, as well as the latter to the old people themselves.

Group activity has been steadily increasing in quantity and quality for the aged. Those who are chronically ill or senile or mentally disturbed have not been so fortunate in the development of social and educational opportunities which could maintain their mental well-being or improve their adjustment.

The congregate home is composed of a group of people, but a group is a social system and does not maintain itself automatically. We must first look at the people so that the social-educational program can be geared to its individual residents or patients. To demonstrate that nursing homes, homes for the aged, and mental hospitals have failed in the past, we need go no further than observations by noted physicians that these centers have actually facilitated senility or accepted the inevitability of over-rapid senescence. That this is not universal now and will be coming increasingly less so in the future, means we must constantly re-assess and recognize the multiplicity of mental changes brought about by biological change and emotional stresses.

The aged can profit from two major types of programs: those directly concerned within the home and those outside its walls. Any social program within the home must take into account the degree of social skills, attitudes and wishes of the individuals. In addition, it must be sensitive to the group environment. As an added ingredient it should also involve the many special publics and utilize their available resources. To illustrate, the program content should be directly related to the interest, desires and needs of the individual old person, as well as the strengthening of group morale and the developing and achieving of goals. The publishing of a newsletter, the evolvement of a residents' council or a crafts activity are good examples of this category.

Libraries or museums are exceptional resources for audio-visual aids and for discussion leaders on a multiplicity of subjects. (This is, of course, true for community clubs, too.) We then see programming within the home (by the residents themselves) and programming from without the home coming to the residents, at their request or consent. A further variation of this aspect is to invite the neighborhood, or special groups, to take part in a home program.

In addition, the residents should be encouraged to go out into the community, either as a group or as individuals. Special interest clubs and classes, camps or golden age clubs are some examples; so is a service to the community like philanthropic solicitation or the manning of civil defense posts.

The nursing program is in an advantageous position to facilitate individual motivation. The 78-year-old woman who prayed every night that she would not be alive the next morning has now actively organized the neighborhood to visit regularly the nursing home where she had formerly been a patient. It was through the encouragement of her social worker, recreation leader and fellow patients that she felt she could live again in spite of a circulatory ailment. Here, indeed, is a wonderful opportunity to help the older shut-in adult through providing a human touch such as reading to him, writing letters for him, or just plain chatting with him.

Even the senile can benefit from a social group program which is based on round-the-clock supervision, therapy activities and the recognition of the need for recreational activities. The senile respond to a social program with no competition and one that is repetitive. Since music and rhythm are related to early life experiences, the senile adult often responds to these stimuli from the past. The basic educational-recreational concepts still prevail, however. In all respects the person is allowed to function on his own level, commensurate with his physical, mental and emotional capacity.

The whole program is determined by agency policy and available facilities—which are influenced by community attitudes—as well as the wishes of the group, the physiological and psychological capacities of its members, and the ingenuity of the recreation leader or teacher. ★

Shelving "Senior Citizens" Too Soon

"Retirement" should Not—And Need Not—End Anyone's Usefulness. Hospitals Have Found Oldsters Valuable As Advisors And Consultants In Many Fields

by **BARBARA CALLAHAN, Special Correspondent**

WITH INTEREST in the aging population ever increasing, and hospitals becoming more and more concerned with the problem of what they can do for the elderly, few hospitals have given much thought to what retired people can do for them.

True there are many individual instances in which hospitals have secured retired executives to work virtually full-time as fund-raisers and advisers on a volunteer basis and a few have hired retired businessmen as accountants and in other capacities in the hospital, but for the most part, according to the oldsters themselves, the hospitals and health agencies have failed to recognize the potential of this great reservoir of talent and skill which is theirs for the asking.

Specifically, for hospitals and other non-profit philanthropic organizations, the sponsors of the "back-to-work" movement for the oldsters emphasize the wide acquaintance of the older employee, particularly the executive whose company has employed hundreds of people and done business with most of the firms of the community. Based on personal experience—through his own dealings and in his own business over the years—the older man has rubbed shoulders in some way with virtually every group and organization or members of organizations, so that he knows immediately who's who in the community and why, and can contribute valuable public relations services in the course of his job, whatever it might be, at the hospital.

A survey of some 30 older members of advisory boards and boards of trustees of hospitals turned up a common complaint: that the hospitals had appealed to them for help in raising funds but had ceased to call on them for advice and assistance after the drive was completed. One man explained that when he asked the administrator why she never called on him, she apologetically explained she "didn't like to bother" him because he'd "already done so much" and she had "taken so much of his time."

In some cities the oldsters are pooling their resources of wide and long experience into organizations which can provide an "expert" in almost any field on request.

In St. Louis, the organization is called Experience, Incorporated, with a current membership of some 44 former executives and professional men with more than 2,000 years of experience in 30 types of business to offer their skills, knowledge and judgment free to small business operators, community agencies, hospitals and other civic projects.

William Charles, president of the organization, who "retired and got busy" in community activities some years ago, says that a list by classes of people who form a part of the old age problem would probably find retired executives either at the bottom of the list or completely missing. Yet, he points out, retirement plans with pensions for executives have become a recognized part of corporations' contracts, so "there is an ever-increasing number of experienced executives who are being retired at ages 60, 65, or 70, and their wide experience, 'know-how' and mature judgment thrown into the discard and scrapped."

In a year and a half, the organization was able to assist in 129 problems brought to it, and its members were represented on virtually all of the community drives and committees, but Mr. Charles considers the failure of the hospitals and voluntary agencies of the Social Planning Council to call on the organization and its members "one of the greatest disappointments of Experience, Incorporated."

One very tangible result was the saving of $15,000 a year by the Community Chest's 102 agencies, when a member named Charles Koven, formerly a merchandising manager for Famous-Barr (a department store), helped them set up a group purchasing

plan for their stationery and supplies.

The organization is supported solely on dues. Each member pays the difference in dollars between his age and 100. Since the minimum age requirement for joining is 60, the newcomer pays $40, while at 80 he pays only $20, and if he lives to 100, it's free.

Mr. Charles explains that the work is free "Because it has given the retired executive an opportunity to create a new place for himself in the community and to repay, at least in part, some of what we all owe to the community in which we live."

That philosophy seems to pervade the movement generally. Maurice du-Pont Lee, of Wilmington, Del., who sparked the movement there to "put used brains back to work" believes that the "independent" man who merely is retired and living on the income of investments made in his working days is in reality no more independent than the oldster on relief, because the wealthy man is entirely dependent upon the people who are earning the dividends of his securities "and has no right to accept this income and not return anything to the community to improve the conditions of those who are supporting him."

The Wilmington program, Consulting and Advisory Services, Inc., was formed to assist small businesses and provide advice and counsel to various community projects, and at the same time, solve the problem of the pensioned oldsters who "have nothing left to do but fret over the world's ills, their stiffening tendons and their golf scores."

Lee points out that the very nature and philosophy of business breeds a temperament poorly suited to loafing, however luxurious, and at the same time, keeps a man so occupied that when he is turned loose at 65 he soon goes to pieces unless he finds some way to be productive, preferably on a part-time basis.

Still another organization, Management Counselors, Inc., of New York boasts a membership of some 30 captains of industry, representing 2,000 years experience in 38 different fields. It is largely the brain-child of Alfred L. Hart, who retired at 54 but who found the fruits of retirement a bore. In conversation with James A. Emery, retired general counsel of the National Association of Manufacturers, they found they echoed the sentiments of a retired admiral who left his doctor's office with the announcement, "I am suffering from acute statutory senility."

Management Counselors, Inc. works on a retainer or per diem basis and will provide services in virtually every field with a retired "expert" to handle the job which falls into his profession.

On a national level and dedicated to a somewhat different program is Senior Citizens of America which publishes a new magazine, *Senior Citizen* which claims to be "a clearing house for all that concerns the second half of life." The magazine intends to keep its readers up-to-date on books and articles of interest to the aging, to acquaint them with the lives of persons who have lived usefully and happily in the last half of their lives, to interchange ideas, to encourage study and other active interests instead of mere vegetation.

W. W. Bauer, M.D., director of health education of the American Medical Association, says "This organization ought to be serviceable in pulling together some of the numerous local and independent projects, but its greatest service will be as a purveyor of ideas to those who have been too busy living the first half of life to plan for the second half."

Hospitals which have a personnel problem might consider the Forty Plus clubs which are springing up all over the country, some of them in hospitals themselves, where older patients inspire each other to recover and "do something."

Forty Plus began in Boston in 1939 when a Remington Rand executive decided to do something about the problem of the job hunter past 40 by forming a club which would band together competent but unemployed men for the purpose of job solicitation and job placement. New York followed Boston and since then clubs have been formed in a dozen or more cities.

The clubs claim they are more particular in their screening of prospective job hunters than any employment service. For example, in New York in the first half of 1949, only 110 applicants out of 1,400 interviewed were accepted for membership. The club makes members aware of their assets and points out men over 40 have one thing to sell, and that's experience. To become a member, the applicant must be willing and able to devote a reasonable amount of time each week to the work of the Club, and every member wants out of the Club because only during his period of unemployment can he be considered a member.

In its arguments for employment for the man past 40, the club lists as assets the member's experience, pointing out that at 40 a man is really ready to contribute to the growth and stability of the company or institution. Also listed on the asset side of the ledger for the older employee are the fact that a mature man will stick to his job; he has results to show, rather than promises; he has judgment; and finally the club quotes records to show that the older employee has less absenteeism than younger men and does not resent understudies but welcomes the opportunity to pass on what he has learned.

All agree that the pool of experienced people will increase rather than decrease as hospitals keep pace with medical advances and continue to turn patients out of the hospital cured of diseases and conditions which not so long ago were certainly fatal.

In a rather startling series in the Minneapolis *Tribune* on "1999, Our Hopeful Future," Science Writer Victor Cohn promises "A Happy Life to 115 is Yours in 1999," based on a series of predictions by eminent physicians and scientists who say the future "could see the defeat of cancer, heart disease, arteriosclerosis, high blood pressure, arthritis, allergies, tooth decay and the common cold."

But "time on their hands" will continue to be a problem, and with this increase in services, hospitals will continue to need personnel to carry on the work to meet the demands of the changing times and changing population, and more and more expert advice, assistance, and above all, FRIENDS, to meet the challenge of the future.

It is possible that hospitals might help themselves to solve their problems by helping in a community problem which grows more pressing with every hospital care and technique advance. ★

Federal Research Grants Include C.H.A. Projects

THE SURGEON GENERAL of the United States, Leonard A. Sheeley, M.D., has announced a series of grants for specialized research in the hospital field. Within the framework set up to evaluate and authenticate the value of various activities proposed, the following projects were awarded recognition.

1. The Association of University Programs in Hospital Administration

Principal Investigator — John R. McGibony, M.D., Chairman, Council of Research, AUPHA

Project—Development of a program of research needed in the hospital field, by determining those needs and the kinds of projects that should be undertaken.

2. The Catholic Hospital Association

Principal Investigator—W. I. Christopher

Project—Library research on a supervisory training program.

[This grant will provide initial funds for a research program aimed toward the establishment of effective tools, techniques and training aids which can be used by hospital administration for the establsh-ing of a "Supervisory Development Training Program."

Although much has already been accomplished in this field by industry, few hospitals have developed an over-all program of supervisory development. Part of the project will undertake to investigate work which has already been done in this field in and by hospitals as well as industrial steps which might have application to the hospital situation.

To assure the effectiveness of this project, study will be included to determine the relationship between good management and good patient care, and how weakness in management affects the quality of this care.

It is hoped that out of this project will come the determination, the definition, the assignment and the teaching of management responsibilities at the various levels of hospital supervisors.

The Catholic Hospital Association will contribute additional funds which will be necessary to carry this project to a suitable conclusion. Actual details of the project should begin early this spring after suitable staff for the study has been selected.]

3. The Catholic Hospital Association

Principal Investigator—W. H. Markey

Project—Study of a safety check list of hospital supplies and equipment.

[Many accidents to patients, employees and visitors are caused in hospitals (and other institutions) solely by the nature or properties of supplies and equipment used there. No existing publication sets forth even a partial list of what these items (and their concomitant hazards) are. Under the grant, The Catholic Hospital Association will develop an alphabetical check list of such items and hazards, for distribution to all hospitals and comparable institutions wanting it. The National Safety Council and other interested groups have promised their co-operation.]

4. University of Arkansas

Principal Investigator—Don D. Stewart, Ph.D.

Project—Experiment in record-keeping by general duty nurses—primarily to determine which kinds of records should be kept and how.

5. Research Foundation of the State University of New York

Principal Investigator — Herbert Notkin, M.D.

Project—Study to develop methodology re the impact of teaching and research on hospital operating cost.

6. American Hospital Association

Principal Investigator — Maurice Norby

Project—Study of hospital planning and licensure laws.

7. American Pharmaceutical Association

Principal Investigator—Don Francke, Pharm. D.

Project—Audit of pharmaceutical services in hospitals.

8. Mississippi State College

Principal Investigator—Marion T. Loftin, Ph.D.

Project—To develop a methodology for studying hospital-community relations.

9. Peter Bent Brigham Hospital, Boston

Principal Investigator—Professor Thomas F. Hill, Sloan School of Industrial Management, M.I.T.

Project—Management study of hospital operations with emphasis on teaching hospital problems.

10. Ohio State University

Principal Investigator—Daniel Howland

Project—Development of a mechanism for evaluation of patient care.

11. American Psychiatric Association

Principal Investigators—Charles K. Bush, M.D. and Alston G. Gutterson

Project—Architectural study of intensive treatment facilities for mental patients.

The total for these 11 projects is $401,960. ★

1956:

Predictions & Prophecies

by **CHARLES E. BERRY, LL.B., M.S., in H.A., F.A.C.H.A.**

THE COMING YEAR promises to be anything but dull for hospital administrators. During the past few weeks several items of unusual interest have been reported by the various news services. One that may have escaped your attention was a court decision to the effect that a nurse anesthetist is not necessarily the servant of the surgeon while administering anesthesia, but is, rather, a servant of the hospital and as such her negligence may be imputed to the hospital. In the past it has been generally accepted that a nurse anesthetist, even though employed by the hospital, was working for the surgeon as a professional and that the hospital was not responsible for her conduct. Whether this case represents a new trend of judicial thought which will be accepted by jurists is difficult to predict. If it does represent such a trend, administrators may have to revise some of their established policies.

Iowa's Medical Practice Act

During the last week of November, at least three news items were worthy of careful consideration. From Iowa came the announcement that the court had ruled that the outdated Medical Practice Act must be interpreted strictly, and that hospitals employing specialists under a straight salary or commission arrangement were practicing medicine. This will generate a lot of heat, but perhaps the air will be clarified during the next twelve months. To those who had studied the law, the result was inevitable—but the issue is far from settled. Here is a controversy which can never result in a victory for anyone and it is my offhand opinion that organized medicine may well win the battle but lose the war. (Plagiarism is one of my vices.)

All administrators have been disturbed over the tactics employed by some of our professional organizations to gain their objectives.

Education and Hospitals

This is an election year. Recently a meeting of educators was held in Washington, D.C. and while its deliberations may seem far removed from the hospital, even a casual analysis of their recommendations will reveal some pertinent facts. Perhaps the most significant was the expression of opinion on the desirability of Federal aid for our school systems.

Just picture for a minute a similar meeting regarding the health problems of this great country of ours. Certainly the delegates representing Mr. Average Citizen would unanimously endorse any proposition that would provide low cost medical care to those who needed it. Leaders of all parties are fully cognizant of this, and I doubt if they will ignore health problems while concentrating on those of our younger citizens. Whether you subscribe to the idea or not, present-day methods of operating hospitals and providing medical care, are going to be carefully scrutinized. Have an opinion, but base it upon reason and evaluate it objectively on practical considerations of need, recognizing the philosophy, good or bad, that permeates the basic thinking of the vast majority of those you serve, remembering that change of itself is not evil and, if properly directed, may be desirable.

Labor's Interest in Health

At first glance the final item on this month's agenda may seem trite, but, believe me, it is not. Two of our largest labor unions have joined forces. Apparently there was some dissension but my favorite TV newscaster has reported the amalgamation to be an accomplished fact. In order to comprehend fully just what effect this may have on our presently constituted voluntary hospital system, we might dust the cobwebs from our memory and recall a speech made in Florida not too long ago by one of the leaders in the labor movement. He unequivocally stated that unions were intensely interested in the health and welfare of their members and were not particularly interested in the mechanics or the objections of those qualified to give such care. Subsequent remarks by lesser officials at various meetings have indicated that this concern for the so-called rank and file has not diminished. Union-sponsored hospitals and clinics are not atypical today, and with the combined resources of the CIO and the AFL pledged to better the worker's position, such service may become commonplace.

Some information coming my way might be interpreted to mean that certain health plans even pay their staff physicians a straight salary and have a permanently attached "no vacancies" sign on the door of the staff's cloak room. I don't believe that the majority of well informed hospital administrators would subscribe to any mass recruitment of this type, but it will be an issue that cannot be ignored. My only hope is that the discussions that are almost certain to arise will not traumatize those who can but sit and wait.

Dominus Nobiscum!

Yes, it looks as though the editorial writers will have a banner year. Committee meetings and emergency conferences will set a new high, numerically at least, and the consumption of coffee will exceed all past records. Perhaps also in the months to come hospital administrators will have time to catch up on their reading; they are almost sure to have plenty of assistance in solving their problems. Our Catholic hospitals will, of course, be subjected to many of these pressures, but we can take solace in our heritage: The ways of the Lord may be beyond the understanding of our finite intellects, but this we do know, that anything done in His name will not go unrewarded and eventually all things will turn out well.

Sounds like fun; maybe I should return to active administration. Anyone need an assistant? ★

Library attendant at St. Gabriel's School of Nursing, Little Falls, Minn., (standing) assists director of school. Uniformed student drops reading slip in box on completing reference assignment.

Sharing a Librarian Can Be Practical!

by **SISTER MARY SHEILA, O.S.F., B.A., Librarian**
St. Gabriel's School of Nursing, Little Falls *and* St. Francis School of Nursing, Breckenridge, Minn.

WHEN FIRST THE QUESTION was raised of sharing our librarian between our two schools of nursing, we were skeptical. Our first reaction was that it would not work, since the two schools concerned are not in proximity, but 130 miles apart. Such a distance seemed to be an obstacle that not all the good will and help offered in either school could surmount. Because of the great need in each for such specialized service, we did try, however. To our intense gratification, the arrangement is proving highly satisfactory.

Perhaps the greatest single factor in making the plan workable is the understanding and harmony which exist between the administrations of the schools (each of which has an enrollment of about 75 students). The fact that both St. Gabriel's School of Nursing in Little Falls, Minn., and St. Francis School of Nursing in Breckenridge, Minn., are owned and operated by the same Religious Community explains this harmony, for the philosophy and objectives in the two institutions are essentially the same.

Both schools have received temporary accreditation from the National League for Nursing and because both are formulating definite plans to make application for full accreditation within the next two years, the Community decided to solve the library problem of each school by placing the same person in charge of both. In this particular situation, the arrangement has been advantageous. The writer had served as librarian for two years in the one school and for approximately a year in the other before the dual appointment was made. Familiarity with the specific requirements and problems of both schools makes rather simple the task of administering the two libraries conjointly.

What system should be adopted for library supervision at one school during the librarian's stay at the other? It was decided that the librarian would divide her time between the two institutions by spending alternate months in each school. The first problem, then, was securing an assistant as full-time attendant for the library in each school. (It is, of course, taken for granted that the professional librarian can not be *replaced* by untrained personnel; however, there are certain areas where a library attendant with some in-service training can give effective help in the absence of the librarian.)

One of the major duties of the librarian is to help students and faculty with reference or research questions and problems. Could a non-professional serve in this capacity? Over a period of time, it has been demonstrated that library attendants *can* be taught to give such assistance. Chief among their problems is a lack of familiarity with medical and nursing terminology, but through study on their part and a certain amount of practice, they have been able to give some help when and where it is most needed. The reference situation does not frequently present a real crisis, however, since the material in both libraries is adequately indexed.

The question might be asked how, under such an arrangement, the librarian can orient new students effectively. That, undoubtedly, does present a problem, since the students in the two schools enter at approximately the same time. It has been solved without too many complications, however, in both schools.

In order to give every possible help, the librarian gives each student a duplicated copy of the library bulletin containing library rules, method of using library resources, a brief listing of the classification numbers used for medical and nursing subjects, index helps and source materials, a summary of the various references, lists of the various professional periodicals (as well as of the non-professional or recreational magazines provided) and an explanation of how to charge library material in the absence of librarian and attendant. Students are also given complete printed instructions on how to record their use of the library, together with the reasons for requiring such detailed information. At the time of a general assembly with the new students, these various instructions are explained in detail.

This introductory lecture is given either by a librarian or, in her absence, by a faculty member who is well acquainted with the library. A follow-up lecture preceded by a short quiz is given. Later, groups of eight to ten students are taken through the library, and facilities are pointed out. Each student in the group is then given a work sheet with various library problems.

Under the supervision of the librarian, students are required to demonstrate their ability to solve these problems by using various library tools and resources. Following two such practice hours, the librarian makes herself available to the students during their study periods in the library and assists them in the actual preparation of their daily class work until it becomes evident that they are at home in the use of the library.

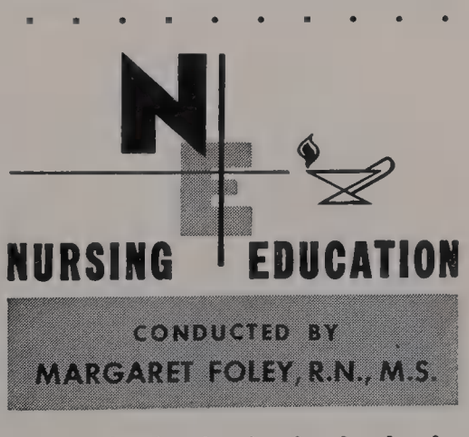
What system of indexing have we found valuable to assist students and faculty to find references quickly? One of the principal aids is the subject *analytic* card in addition to the usual subject cards in the catalog. Once a student has learned how to make use of the card catalog, she has at her fingertips a mine of information.

In conjunction with the use of the card catalog, students are taught to make use of various indexes. Because the number of subscriptions to professional medical and nursing periodicals is somewhat limited at present in both schools, indexes such as the *Quarterly Cumulative Index Medicus* are not too profitable. Hence we have found it far less expensive to make our own index cards on all incoming professional and non-professional periodicals with the exception of the *American Journal of Nursing, Nursing Outlook,* and *Nursing Research,* for which we use the bibliography cards. We index only those articles in other publications which will be of value either to faculty or students in their particular areas of study or teaching.

In addition to our own card index, students find great help in making use of such aids as the cumulative indexes of both the *American Journal of Nursing* and HOSPITAL PROGRESS, as well as of the *Catholic Periodical Index.*

A rather extensive pamphlet collection kept in labeled "Magafiles" and indexed in a separate pamphlet card file according to subject keeps students and faculty posted as to sources of additional material available. The vertical file contents are also indexed in the periodical file index so that students in search of all the available material in the library on any given subject will have a complete bibliography listed in one place. Index cards for the vertical file are marked "Clipping File," with a reference made to the subject head under which the article will be found.

Among duties of the librarian which are easily delegated to the attendant in each of the libraries is the practice of keeping up the daily and monthly statistical records. To determine the exact amount of use of our libraries (including the ward and medical libraries) and the type of material used, we have developed a simple but comprehensive system of tabulation. The accuracy of the system depends to a considerable degree on the students



and faculty, who are called upon to leave their own records of attendance and usage.

Boxes with small slips of paper are provided on library tables, in the ward classrooms, faculty room, and special libraries and departments throughout the hospital and school of nursing. Students and faculty, after having used any materials, leave a record of the number and kind. Slips for recording attendance are placed at the door of the library. As each reader leaves the room, she makes a check mark beside the day of the week printed on the slip. Similar slips are placed at the door in the medical library and in all ward libraries.

Each morning the library attendant collects this information throughout the hospital and school of nursing and records her findings on special forms. At the end of the month the librarian makes out a complete statement of library usage, and sends copies of the record to the director of the school and to each faculty member. It has been found that such a system keeps faculty members informed of their own, as well as of student use of the library, and gives them some means of measuring the type of reference work the students are doing and the amount of reading done in any given area.

Do students and faculty rebel at this constant record leaving? Surprisingly, no. Once the value has been explained to them of knowing how the library resources are being used, and what they themselves can learn from such records, there is no problem other than occasional human forgetfulness. The librarian or her assistant does her share in prodding memories when occasion arises.

Even though the "shared" librarian must divide her energies, her effectiveness in either situation is not halved. As far as membership in faculty committees is concerned, she functions as a member of the library committee, for which she serves as chairman; she is a member of the curriculum committee, and she attends faculty meetings in both schools.

Of course, her participation in faculty in-service education programs and attendance at meetings must necessarily be alternated every other month. However, she is present for such meetings and programs half the time, and the two institutions, knowing her schedule in advance, plan her program participation accordingly. Indeed, as far as the librarian herself is concerned, by such dual faculty membership she benefits more if she served in only one school.

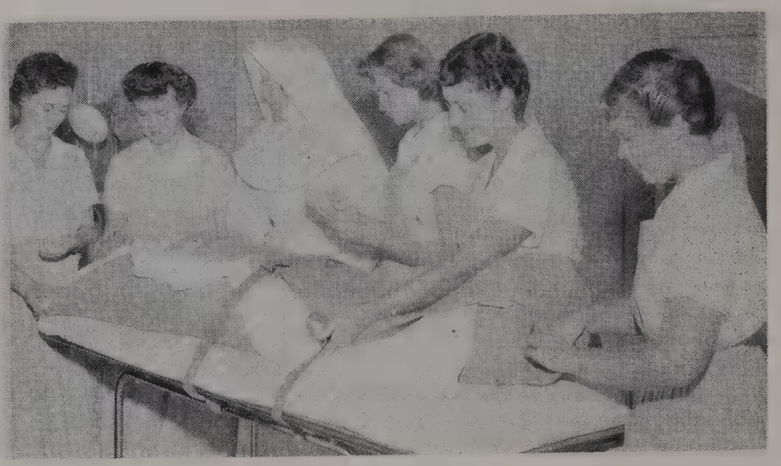
There are no overwhelming obstacles in effective service to both

schools sharing the same librarian. We find that it is just as easy, for example, for the librarian to write two monthly library bulletins as to write one, since the content requires only slight change to adapt it to each situation. It is a comparatively simple thing to make out two slips calling faculty attention to articles of interest in incoming current professional periodicals and to mail the duplicate set to the library attendant in the other school for distribution to faculty members. Annual inventory, too, works out when taken at one in December and at the other in July.

Problems of cataloging likewise are relatively simple. Many books acquired in one school are duplicated in the other, and since both schools adopted the Dewey Decimal Classification some years ago, the cataloging system offers no difficulty. We find that our equipment expense is considerably lessened by sharing the tools in each school, and where one person is handling the job, there is minimum transportation of books. Oftentimes, a car will happen to be going to or from either place, so even the slight inconvenience of becoming a "human book barrow" is eliminated!

In making out the monthly or weekly periodical index cards, it is simple to have the attendant make duplicate cards and to mail one set to the other school, so that references are kept up to date. Stencils of duplicated forms used for statistical records for monthly and annual reports, overdue and renewal book notices, book request blanks, and current periodical and film notices can easily be transferred from one school to another.

The system described here is not by any means regarded as ideal, but rather as a "make-do" until additional personnel can be prepared. Keeping in mind that the librarian is shared, not on a consultation basis, but as actually being in charge of both libraries, this arrangement fills the present need of the two schools concerned. It further meets the National League for Nursing requirement for accreditation relative to the library. That there is a certain amount of personal inconvenience and "wear and tear" from frequent traveling cannot be denied, but balanced against the gains in each of the situations we feel that long distance sharing of the librarian is practical until a full-time professional can serve with the personal service for which there is no substitute. ★



High School Girls Are Junior Nurses Aides

AT MERCY HOSPITAL in San Diego, seven teen-age girls who volunteer their services for numerous essential duties, are putting to rout some prevailing notions concerning the much criticized "younger generation." All but one are Protestant students in public high schools, and these 15- to 17-year-olds are also demonstrating that religion knows no barriers where charity and care of the sick are concerned.

As members of the first Junior Nurses Aides to be used in any hospital in San Diego, these girls are giving of their time and—solely for love of the work—performing jobs that would be a credit to much more mature people, according to Sister Maureen, director of nursing services at the California institution.

Junior Nurses Aides are part of the Future Nurses clubs (a project sponsored by the Women's Auxiliary to the San Diego County Medical Society) in San Diego high schools. Six clubs were inaugurated some months ago, but the current class of aides at Mercy is the first actually to work in any hospital. Prior to assuming actual duties in the institution, they received an intensive 12 hour course in basic home nursing from the Red Cross.

The aides at Mercy come from various public high schools, only one from a parochial school. They work about four hours a day, choosing their own days and hours of service. During the school term they work week-ends. They are free to leave the organization at any time. Several of the girls have become so interested, according to Sister Maureen, that they have put in many extra hours of their own volition.

Junior Nurses Aides in the California hospital are proving so valuable that it is felt they will eventually play a vital part in alleviating the nursing shortage. By giving teen-agers a taste of "medicine" early in their formative years it is hoped many will see fit to choose nursing as a career.

The girls who are currently setting the precedent at Mercy are: Margaret Berndes, Judith Brink, Susanne Riley and Susan Smith, each 16; Barbara Blanton and Beverly Piper, 17 and Joanne Urquhart, 15.

Using Records in Clinical Research

by RICHARD E. JOHNSON, M.D.,* Medical Director ■ The Ellis Fischel State Cancer Hospital, Columbia, Mo.

THE USE OF MEDICAL RECORDS in clinical research may be said to consist of two major problems: the first is to put information into the records; the second is to get it back out. The medical record librarian plays an important role in the solution of both of these problems. My discussion will deal only with the latter—the problem of extracting information from medical records. I shall first describe an actual clinical investigation which I recently conducted and shall then discuss the methods by which the necessary information was obtained.

The Question

Every clinical investigation begins with a question. The investigator is seeking the answer to some specific question that has come up in the course of his work. The question behind the investigation which I shall presently describe arose in the following manner. Most pathologists feel that they can predict the outcome in cases of malignant tumors (or cancers) from the appearance of the histologic sections viewed through a microscope. They learn through experience to associate certain appearances with a favorable or unfavorable result. On the basis of appearance, they classify malignant tumors into "good," "bad," and "inbetween." No pathologist would use such vulgar terminology, of course; instead he employs Roman numerals and calls them histologic grades, or simply, grades. Thus, a "good" tumor will be Grade I, a "bad" tumor, Grade III, and those inbetween, Grade II.

Now the world is full of skeptics—and some of them become pathologists! Every once in a while you will encounter such a pathologist who says that this practice of prediction through histologic grade, as practiced by his confreres, is nothing but a fraud—unintentional and harmless, but a fraud nonetheless. This skeptical pathologist (or pathological skeptic, as his confreres would say) will call attention to the fact that before a pathologist will make a diagnosis from a histologic section, he insists upon having certain clinical information. Now, this clinical information is in itself, he says, a perfectly good basis for predicting the outcome. The skeptic says that looking through the microscope is nothing but a gesture, for the pathologist's mind has been influenced and his prediction in part determined by this clinical information. His prediction is based not so much on what he sees through the microscope, but on what he has been told about the patient.

This is a valid criticism, and the obvious answer is for the pathologist to make his prediction without possessing any clinical information. In clinical practice, this would be inadvisable, but as a clinical investigation it would be both possible and informative. The investigation which I shall now describe was designed to do just this—to test the possibility of predicting the outcome by looking at the histologic section without possessing any clinical information.

**Dr. Johnson is also Pathologist, Director of Laboratories and Director of Medical Records.*

The Investigation

I chose as the test tumor, adenocarcinoma of the endometrium. The first step was to obtain the records of all patients with this type of cancer. This is the responsibility of our medical record librarians, and the means by which they do this job will be discussed later. Suffice it to say at this point that about 125 charts were pulled for me. Within a short period of time, somewhat less than an hour, I quickly ran through these records, extracting just two items of information. These were the record number and the slide number on the pathology report. I deliberately avoided taking note of the outcome of the case. Even if I had wanted to cheat, the task of memorizing the record number, slide number, and outcome for each of 125 cases in less than an hour's time would have been beyond my capacity!

After a two weeks' delay period (to allow any chance associations of numbers and outcome to be forgotten), the slides were obtained from the pathology department's files. I then reviewed these several boxes of slides, recording two points of information—the slide number and my prediction of the outcome; i.e., the histologic grade. It is evident that this prediction was made in the absence of any pertinent clinical information.

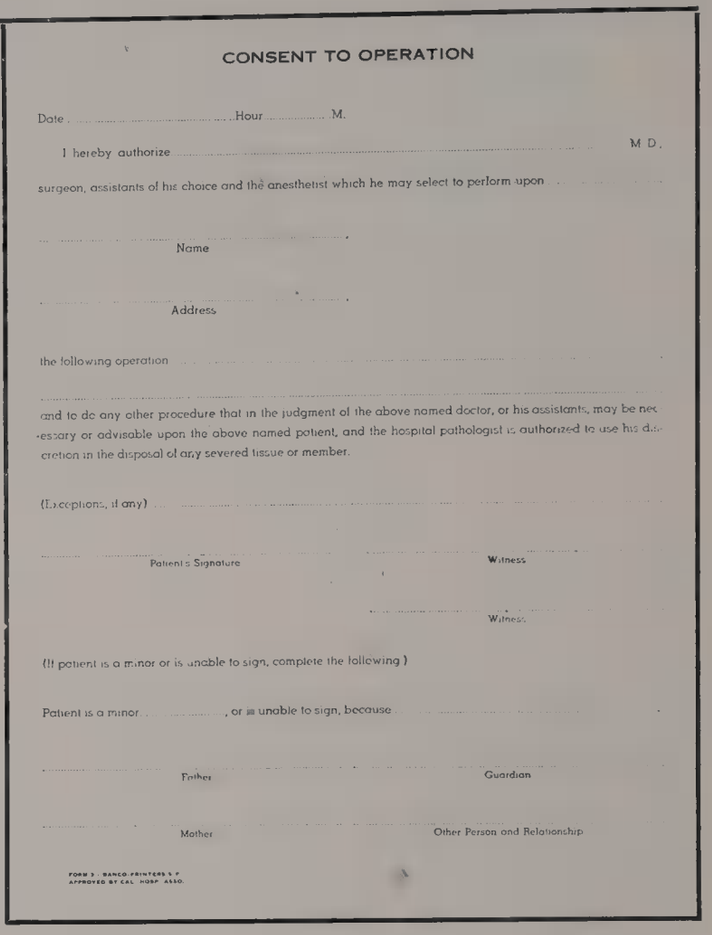
The second step was to return to the 125 records and take out several more items of information, including the stage of the disease, method of treatment, and outcome. These were entered on individual cards, one for each case. To these same cards, I transfer-

(Continued on page 96)

LAW

CONSENTS: A Realistic Approach

by JAMES E. LUDLAM
Musick, Peeler & Garrett
Los Angeles, Calif.



CONSENT TO OPERATION

Date ..... Hour ..... M.

I hereby authorize ..... M.D.,

surgeon, assistants of his choice and the anesthetist which he may select to perform upon

..... Name

..... Address

the following operation .....

..... and to do any other procedure that in the judgment of the above named doctor, or his assistants, may be necessary or advisable upon the above named patient, and the hospital pathologist is authorized to use his discretion in the disposal of any severed tissue or member.

(Exceptions, if any) .....

..... Patient's Signature ..... Witness

..... Witness

(If patient is a minor or is unable to sign, complete the following)

Patient is a minor ....., or is unable to sign, because .....

..... Father ..... Guardian

..... Mother ..... Other Person and Relationship

FORM 3 - BANCO PRINTERS S. F.
APPROVED BY CAL. HOSP. ASSO.

IN THE FIRST TV BROADCAST of its 1955-1956 season, "Medic" featured a dramatic situation involving a psychosomatic adult patient who was refusing to give her consent to an operation required to save her life. I am sure many medical librarians watching the program crossed their fingers as the drama reached its climax, with the surgeon wheeling the patient off to surgery, relying upon the oral consent of a patient, hysterical with pain and under great pressure from the doctors to give her unwilling consent. As is usual with TV programs, the operation was 100 per cent successful, but the thought went through my mind that if the operation had not been a success, the case could have been featured on the following week's "Mr. District Attorney," and in the latter program the doctor and hospital would be prosecuted for operating upon a patient without a proper consent.

From a strictly legal point of view, the consent in the TV program left much to be desired. From a humanitarian point of view a desirable result was obtained. Thus we are faced with the real impact of the consent problem, and the reason why record librarians and surgery supervisors get grey. A realistic review of the problem of consents would seem to be in order.

We can start with the basic assumption that no medical treatment can be given without a proper consent. From a legal point of view this consent can be oral or written; in some situations it is implied from the needs of the patient. Applying these general rules to specific situations is not easy. Furthermore, in operating a hospital we are engaged in a humanitarian function and under certain circumstances we cannot be bound by the strict legal niceties. There are circumstances under which we advise hospitals that in spite of the risks which may be involved, it is better to proceed with the treatment than to incur an extended delay that may seriously prejudice the condition of the patient as well as adversely affect our public relations.

Nearly all hospitals obtain a general consent to treatment that is used for both medical and surgical patients, with a simplified form used for outpatients. This form is intended to protect both the hospital and the attending physician, although we recommend that the doctor obtain his own signed consent from the patient. Most of these forms were drafted in the 19th century and fail to give proper protection to the hospital and its staff. On behalf of the California Hospital Association the writer collected a large variety of such forms, and after consulting with many hospital attorneys, as well as legal counsel for the medical profession, prepared the following language to be used as a part of the general admission form:

"Medical and Surgical Consent.

The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physicians, and the undersigned consents to any X-ray examination, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physicians."

However, we do not recommend that a hospital rely on the above general language in surgery cases, but provide a separate consent which is as follows:

Attention is called to the fact that specific reference is made to the possibility of more than one doctor treating the patient, and that the separate function of anesthesia is recognized. Furthermore, protection is provided if the pathologist retains a specimen for the pathology museum or for instruction purposes. An opinion rendered by the County Counsel of Los Angeles County this year indicates that the retention of such a specimen without consent may lead to not only civil liability but even criminal responsibility.

In drafting the above form we stirred up a controversy with those attorneys who advocated that the form should require not only a general description of the operation but also a preoperative diagnosis. Their position, based upon experience in trying malpractice cases, was that a consent must be very specific to be effective as a defense. There have been instances where a trial court has found that a consent was so general in form that the patient did not in fact know he was consenting to the particular procedure that followed.

On the other hand, we all know that for many valid reasons a pre-operative diagnosis may not predict the true condition and the actual operation may be quite different from the one originally contemplated. For this reason the specific consent may lead to embarrassing explanations and possible controversy. Weighing all of these factors, it was our determination to use the general form.

Having prepared the form, the next question is to determine who should sign it. The law on this subject will vary from state to state, but perhaps a description of the rules we follow in California will be helpful as being fairly typical.

(A)—A series of recent California decisions has clearly established that the consent of the spouse is not required to the operation on the other partner of a marriage. In other words, either party may freely consent to his or her own operation, even though the other party refuses to consent. This is not the law everywhere, and as a practical matter we recommend the obtaining of the consent of the spouse, whenever possible, to any serious operations, simply to avoid future controversies and unpleasantness. Many married persons, particularly husbands, have the mistaken view that they have some property right in their spouse and wax indignant if they are ignored. Unfortunately some will even use their failure to consent as an argument to avoid payment on a just bill. This is not a good defense, but it may lead to bad feeling and additional expense.

(B)—Minor children present a wide variety of consent problems. First of all, it is assumed that a consent is necessary to treat a minor. However, the definition of minority (or infancy as the courts call it) varies from State to State. In California, all persons under 21 are minors, but a person who is both 18 and married is deemed an adult for consent purposes. It will be noted that there is no provision exempting married persons under 18 from the usual disabilities of infancy, and a consent from the parents is required. As a practical matter in this and similar situations, we in California take consents from both the married minor and the parents. Needless to say, the spouse is not happy about this state of affairs, and we recommend taking the consent of the spouse too, in order to salve injured feelings, even though we know that it is of little or no value from the strictly legal point of view.

(C)—In California we have an increasingly active agency adoption program in an effort to eliminate the traffic in children by a few well meaning but untrained and irresponsible persons, as well as some who are frankly interested in the financial aspects. These agencies were faced with a real problem in obtaining proper medical and hospital care for unmarried mothers who were minors. In many cases these girls were unwilling to contact their parents to obtain consent to prenatal, delivery and postnatal medical care, and as a result these unfortunate girls were forced to seek out practitioners who were not bothered by correct legal procedure.*

*As Sister Thomasine of the Holy Family Adoption Service has so often said, the bad girls do not find themselves in these difficulties, and we were all most anxious to solve this problem. To meet this situation the hospital association and the social agencies joined in obtaining an amendment to the law, permitting an unwed pregnant minor to consent to medical treatment in connection with her pregnancy. As a result, these girls now have full access to the best medical and hospital service available in their time of critical need.

(D)—Who has the right to consent to the medical care of a child placed for adoption? If it is an agency adoption and the adoption agency has taken a relinquishment, then the agency has the right to consent, but if it is an independent or private placement, the adopting parents may find they have no right to consent to such treatment, and may be unable to find the natural mother to do so.

In a case of elective surgery, this may present a real problem. In California our hospital association had recommended a form of release of a child (when released to other than its natural parents) which carries a special provision of continuing medical consent. The form required by the State Department of Social Welfare for reporting all instances in which a child is removed from a hospital by others than its parents does not include such a consent, and we request hospitals to have both forms executed, as a protection to the infant.

(E)—The most difficult question of all, from the legal point of view, is determining who may consent to treatment of the children of minor mothers. It is our opinion that the mother of the child may execute a valid consent; if the child is illegitimate, then only the mother can consent until such time as the father has legitimatized the child. If the child is legitimate the consents of both father and mother are recommended. If the husband is a step-parent, he does not have legal cutsody to consent unless he has legally adopted the child.

(F)—If the consent of a parent is required, then the consent of either appears to be proper, unless there is a divorce, in which event the one who has custody has the right to consent. However, here again we recommend the obtaining of the consent of both, to avoid potential arguments due to the almost complete lack of legal authority on this subject.

(G)—Another series of situations, all similar in nature, that give rise to difficult questions are those involving minor children away at school, in a camp, or in a foster home. Although a much better job is being done in obtaining general consents in advance from parents, all too often no such consent exists.

From a strictly legal point of view we might take the position that unless it is an emergency, nothing can be done until the consent is received,

(Continued on page 95)

Iowa Case Closes Until Appeal

An Iowa District Court has ruled in the case of *Iowa Hospital Association v. Iowa State Board of Medical Examiners* that it is illegal for hospitals in the State of Iowa to hire medical specialists as staff members and then bill hospital patients directly for the services of such specialists. Judge C. Edwin Moore held in a 32-page opinion that this procedure in regard to pathologists and radiologists, in effect, constitutes practice of medicine by a corporation, thus violating the Iowa law which limits such practice to duly licensed practitioners. Facts disclosed in the trial indicated that for many years hospitals in Iowa have maintained laboratories for medical specialists and have retained such specialists as staff members. These men have received salaries or a percentage of the fees, and the hospital charged patients directly for their services.

Judge Moore ruled that this constituted illegal fee-splitting without the consent of the patient. He further held that both physicians and hospitals had violated the law in this respect. He stated that, "the Court is not to be understood as holding that the plaintiff hospitals cannot own and maintain the facilities of pathology and x-ray laboratories and receive just compensation for their use, as certainly these facilities are essential and necessary parts of a modern hospital, nor that the operation of said laboratories within the law need affect the care and treatment to be given patients."

Alternatively, he suggested that the physicians may own the equipment in the pathology and radiology departments if they and the hospital so prefer. He indicated that the laboratory technicians may be the employees of either the hospital or physician. In rendering this decision the Court did not limit it to proprietary hospitals. It ruled that all hospitals, including non-profit charitable corporations are subject to this decision. Judge Moore stated, "the law applies to all and must not be violated even if the intention is only to do good." He also rejected the argument that the work of the technicians done under the supervision of the specialist does not constitute the practice of medicine. Categorically he stated, "the work done by the pathologists, radiologists and the technicians working in the pathology and x-ray laboratories constitutes the practice of medicine."

Judge Moore suggested that arrangements could be made by and between the hospitals and the medical specialists so that the beneficial results flowing from mutual cooperation would not be lost. For instance, one suggestion was that the hospital, which owns the laboratory space and the equipment, lease the property to the specialist. This solution has constantly been advanced by many medical specialists. Some hospitals have already entered such arrangements. However, before a hospital actually concludes such an arrangement with the medical specialist, it would be well to take into consideration the tax implications of such agreements. Conceivably, tax assessors might hold that a portion of the hospital premises is not being used exclusively for tax exempt purposes. This would subject the said portion of the property to real estate taxes. In some states where such a situation prevails the whole property is subject to taxation. Obviously, this is a situation which varies with the local law.

Another suggestion by Judge Moore is that the hospitals permit the medical specialist to bill the patients directly but that they (the hospitals) should collect the fees for the doctor. This would place the hospitals in the unenviable position of collecting bills for the medical specialist for the benefit of the specialist.

The Court also observed that the quality of service may suffer unless the services are under actual physician control and supervision. At another place the Court states that there has been no actual interference by hospital trustees or administrators with the professional services of the pathologists and radiologists. These contradictory statements are characteristic of much of the basic controversy. One thing is obvious—this decision will have very widespread implications. It will no doubt affect the coverage of radiology and pathology costs by Blue Cross. It could very readily give certain specialists in the community a complete monopoly. The decision, of course, will be appealed to the Supreme Court of Iowa. However, the District Court has made the important findings of fact which will have substantial bearing on the ultimate outcome of the case.

Is a Hospital a Charitable Institution?

At approximately the same time that the Iowa decision was rendered, the Supreme Court of Oregon had occasion to decide a case involving the following two points; whether a hospital is a charity and whether a charitable organization is entitled to immunity. In *Ackerman v. Physicians and Surgeons Hospital* the Court concluded that if it be the law that—under the circumstances of the case—benefit, gain or advantage accrues to staff physicians, then there can be no charitable corporation. This decision should be kept in mind before any contracts are made with medical specialists lest such arrangements affect not only the tax exempt status of the organization but the whole question as to whether it is a charitable corporation.

Another situation developing in the Middle West which is of considerable interest because it definitely has national implications, is the attempt to "organize" certain hospitals in Illinois (including Catholic ones). This labor organization movement is being spear-headed by the American Nurses Association, which has its office in New York City. According to information received here, the organization of the nurses is for the purpose of securing (a) job security (b) higher wages.

At the present time, hospitals are exempt from the provisions of the Taft-Hartley Act. However, in many states they are subject to the provisions of state law with respect to labor relations. As this situation develops it will be more fully reported in this column. ★

Ford's Half-Billion Gift Rocks Health & Education Fields

Approximately 3,500 voluntary, non-profit hospitals will receive $200,000,000 of total; Catholic hospitals to obtain $60,385,400

IMPACT? TERRIFIC! Never in the history of American philanthropy had so much been given at one time by one donor. Who was this benefactor? The Ford Foundation. Who benefited? Voluntary non-profit hospitals, and educational institutions (universities and colleges).

Hospitals received about $200,000,000 of the total; the rest was earmarked for raising the remuneration of teachers in the field of higher education.

Population increases and the advances of medical knowledge in recent years have placed heavy burdens upon the facilities of the nation's voluntary non-profit hospitals.

Several hundred thousand additional general hospital beds are needed. Old or obsolete buildings require replacement or modernization. Many hospitals need better equipment. All hospitals need to extend the scope of their services if they are to serve satisfactorily as health and rehabilitation centers in their communities.

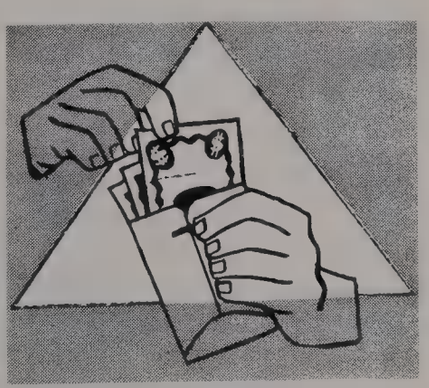
Moreover, the rising cost of both hospital construction and hospital operation places these institutions in a serious financial dilemma. Many still manage to continue operating without deficits, but they do so only through the sacrifice or curtailment of services or facilities important to community health and welfare.

The pressing need is for funds to expand or modernize present facilities, and extend services to keep pace with the rapid development of medical science.

Toward the vital goal of improving and extending their services to their respective communities, the Foundation will make available from $10,000 to $250,000 to each of approximately 3,500 voluntary, non-profit hospitals in the United States, its territories and possessions.

The recipients will be those hospitals now accepted for listing by the American Hospital Association, plus other voluntary, non-profit hospitals whose applications for listing are now pending, provided they are approved for listing by the Association.

The terms of the grants will place full responsibility on the governing authorities of each hospital to spend the funds in accordance with local needs and problems. Use of the funds will be permitted for any program of improvement or extension of hospital



service, but not for operating expenses for services currently being performed by the hospitals. A particular purpose of the grants would be to assist hospitals desiring to do so to achieve full accreditation with the Joint Commission on Accreditation of Hospitals. Programs may be in the form of:

(a) Improvement of or addition to facilities or services;

(b) Additions to or training of personnel;

(c) Conducting research.

Within these broad limits, the recipient hospital may use its grant in any area of hospital service, including, for example, disaster planning, mental illness, prematurity, rehabilitation, handicapped children, preventive or diagnostic services, out-patient care, or any other area which in the opinion of the hospital's governing board would best serve its community.

Hospital governing boards will be required to submit evidence of tax exemption before receiving a grant, to report preliminary plans for use of funds within three months of acceptance, and to report at the end of two years on actual or projected use of the funds.

The amount of each grant has been computed on the basis of patient days of service provided by the hospital, and the number of births in the hospital. Patient days reflect the extent to which a hospital is used. Days of care given to newborn infants are not shown in the patient-day tabulation; therefore, the number of births is added to patient days as a measure of an important hospital service.

The reaction of the Rt. Rev. Msgr. Robert Maher, President of The Catholic Hospital Association, was a wire "on behalf of the Executive Board of The Catholic Hospital Association . . . to express the deepest appreciation and gratitude for the unprecedented gift made by the Ford Foundation to the voluntary hospitals of the United States." ★

SCHOOLS OF NURSING MARK 50TH ANNIVERSARIES

City Hospital School of Nursing, Mobile, Alabama
Daughters of Charity of St. Vincent de Paul, Western Province

St. Edward's, Fort Smith, Arkansas
Sisters of Mercy of the Union, St. Louis Province

St. Vincent's Infirmary, Little Rock, Arkansas
Sisters of Charity of Nazareth

St. Alphonsus, Boise, Idaho
Sisters of the Holy Cross, Western Province

St. Bernard's, Chicago, Illinois
Religious Hospitallers of St. Joseph, Province of St. Joseph

St. Francis, Kewanee, Illinois
Franciscan Sisters of the Immaculate Conception

Oak Park (Illinois) Hospital School of Nursing
Sisters of Misericorde

Mount Carmel, Pittsburg, Kansas
Sisters of St. Joseph of Wichita

Sacred Heart, Cumberland, Maryland
Daughters of Charity of St. Vincent de Paul, Eastern Province

St. Mary's, Rochester, Minnesota
Sisters of St. Francis of the Congregation of Our Lady of Lourdes

Mercy, Charlotte, South Carolina
Sisters of Mercy

Mercy, Hamilton, Ohio
Sisters of Mercy of the Union, Province of Cincinnati

St. Joseph's, Fort Worth, Texas
Sisters of Charity of the Incarnate Word, San Antonio Province

Providence, Waco, Texas
Daughters of Charity of St. Vincent de Paul, Western Province

Misericordia, Edmonton, Alberta, Canada
Sisters of Misericorde

St. Joseph's, Peterborough, Ontario, Canada
Sisters of St. Joseph

"Is this place recommended by Duncan Hines?"

NUTRITION OF AGING —Chope and Breslow

Concluded from page 48

were edentulous. The maintenance of good ascorbic acid intake and blood levels may be important to the support of good oral hygiene—not only for preservation of the teeth but also for prevention of serious gingivitis.

Discussion and Summary

This study of the nutritional status of the 577 volunteer healthy subjects in relation to their health and expectancy provides:

1) A living example of the close integration of various disciplines associated in the health field—including physicians, nutritionists, laboratory technicians, statisticians, public health nurses, institutional managers and the public—to work toward the solution of a complex problem.

2) Further evidence of the relationship between hypertension and overweight, and mortality.

3) A suggestion that among persons over 50 years of age, those with high levels of total blood cholesterol have a lower mortality rate than do persons with low amounts of total blood cholesterol.

4) Indication that older persons with low blood levels of vitamin A, niacin and ascorbic acid suffer a higher mortality rate than do persons with greater amounts of these substances in the blood.

5) Indication of poorer dentition among persons in low income groups than amoung those enjoying a higher level of living. ★

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Johnson & Johnson

Combine Souring and Bluing for Economy and Results

by A. E. BURROUGHS • Richland, Ind.

WITH WHITE COTTON FABRICS making up the major portion of the daily work for the hospital laundry, and these white fabrics washed frequently, the job of retaining a true white for the work is a big task.

While every step of the washing operation from the suds to the rinses, the souring, the bleaching all contribute to obtaining the whitest white for these fabrics, bluing is the finishing touch to insure a pleasing appearance for the hospital linens and uniforms.

At all times, the bluing operation must be considered as a finishing touch, a process to neutralize that natural yellow white of fabrics by tinting the fabrics a faint blue. This natural yellow plus the tint of blue improves the appearance of the work for a whiter white. This bluing or tinting is a surface dye operation, with the temperature, and other factors, affecting the job done. It is never a cover-up method of general poor laundry work, and is always only a finishing touch for a better appearance on the fabrics laundered in the hospital laundry.

The best bluing results come from the right selection of the blue, knowing how to use that blue, when to use it, and knowing some of the causes of difficulties reported in the bluing results.

Many years ago the insoluble blues were in extensive use by hospital laundries. But today's hospital laundry interviews reveal that the major portion of these plants are using the soluble blues, which are principally derivatives of aniline dyes.

Of this soluble blue group, both the non-sour blue (used where little souring is done) and the sour blue (used where the souring is included in the operation), are in use. In addition, many hospital laundry managers report satisfaction with the combination or all-purpose blue which is adaptable to acid, alkali or neutral conditions.

Whichever type of blue is selected for the hospital laundry, a simple test for the fugitive value of the blue must be made to avoid accumulation of blue in the fabric, since this causes the discoloration complaint.

A Tennessee hospital laundry manager gave us this simple test in use there. He said, "We simply soak some sample pieces of white cotton fabric in a concentrated stock solution. The fabric is dried, and then put through our regular white work washing formula. If the blue tint washes out completely, then we know we have a good blue with a good fugitive value and avoid a lot of difficulties later."

And from Missouri came this test for checking the fugitive value of the blue selected, "We pour 25 c.c. of water in a small medicine bottle. Then we add a blue solution to color a very dark blue. Then, we add bleach—drop by drop—until this blue color disappears. If the blue is one that will wash out quickly and easily, the solution in the medicine bottle will be as clear as the water from the tap. If it is not clear, a sort of murky color, it is a blue that will build up on the fabrics, and it's not for us!"

For the best method on using the blue purchased for the hopital laundry, the best information is obtained from the manufacturer. Follow their directions for mixing the stock solution carefully, and follow their recommendations with equal accuracy. These methods are tested in their laboratories

Delaware Valley Hospital Engineers Meet

The Hospital Chief Engineers Association, representing hospitals in the Delaware Valley, held its December monthly meeting at the Chestnut Hill Hospital, Philadelphia.

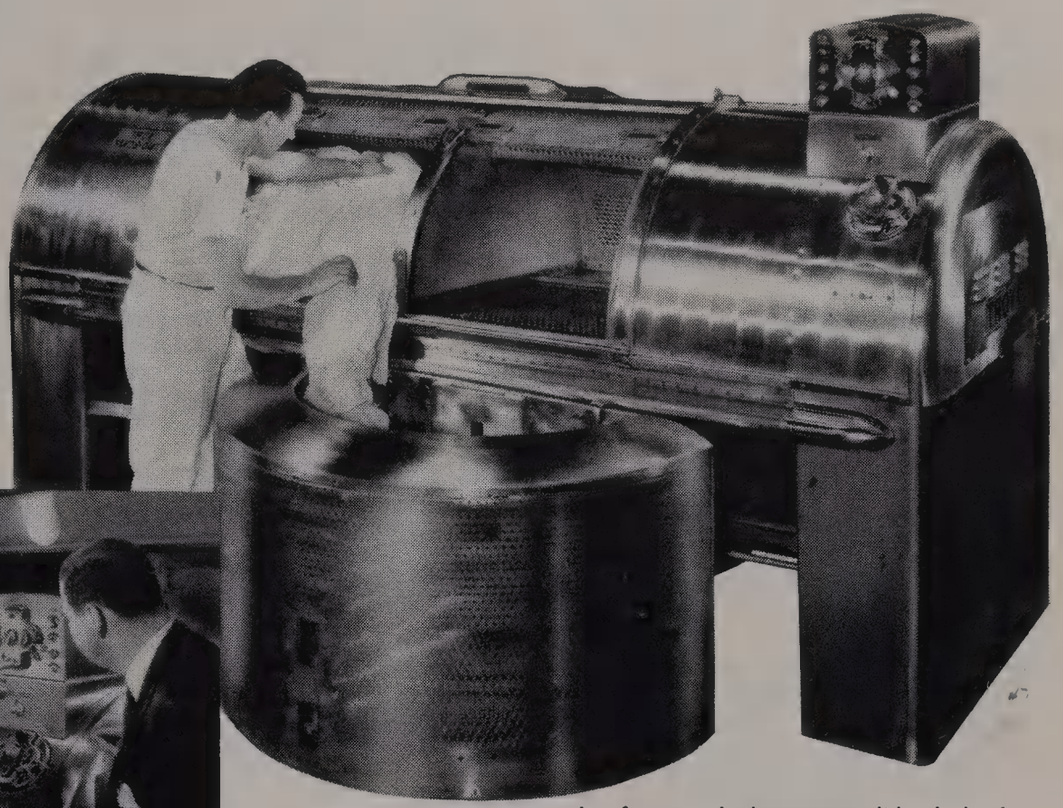
Preceding the meeting, dinner was served by the hospital, through the courtesy of J. D. Miller, the administrator. Mr. Miller has encouraged the Association since its beginning some seven years ago.

As is the custom at each monthly meeting some educational feature or topic of interest was presented. This month, through the courtesy of the Hajoca Corp., Kenneth Chamberlain presented "The Dramatic PVC Story—The Origin and Development and Application of Unplasticized Polyvinyl Chloride Materials."

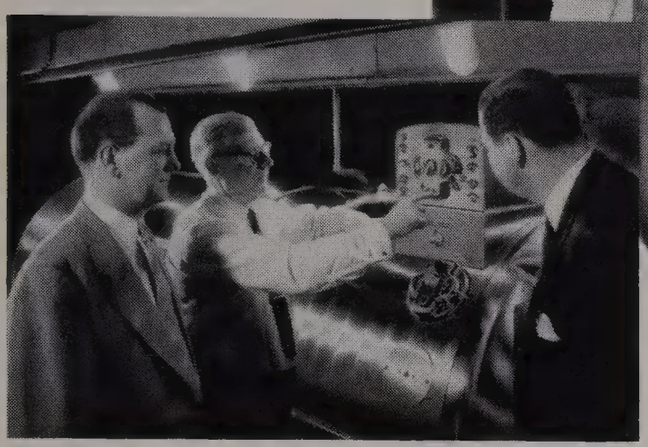
Final preparations were made for the organization's 5th Annual Banquet. This is the one affair each year which members and their families attend.

Any one in charge of hospital maintenance who wishes to join the Association can do so by sending his name to the secretary:

Joseph Marnell
c/o Nazareth Hospital
Philadelphia 15, Penn.



Controls of the Troy Fullmatic Washer. Operation is fully automatic, even adding of supplies.



In a few seconds, the operator slides the load out from the labor-saving "Slyde-Out" Shelf.

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	FULLMATIC® WASHER	ELECTROMATIC WASHER	ELECTROMANUAL WASHER	LAUNDRITE WASHER
CAPACITIES (in pounds)	150, 225, 350, 400	60, 95, 150, 225, 350, 400		25, 40
CONTROLS	Semi-automatic. Fully automatic.	Simplified semi-automatic.	Manual, with easy-to-operate controls.	Automatic or semi-automatic.
UNLOADING TYPES	"Slyde-Out"® Shelf, Removable Partition or Open Pocket			Open End

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Without obligation, please send me full data on the washers and features I have indicated.

WASHER NAME

CAPACITY

CONTROLS

UNLOADING TYPE

ORGANIZATION

ADDRESS

CITY ZONE STATE

NAME AND TITLE

(Continued from page 74)

for your satisfaction in the hospital laundry, making them your best source of information on how to use the blue purchased.

A much debated question, and one with many varied professional opinions, is "when to blue."

In some hospital laundries, bluing is done in a separate bath following the sour. A fairly high level of water is added to prevent uneven bluing.

Hospital laundries faced with highly alkaline water are finding that it is much more economical to blue right after the rinsing operations, and then sour. Where this method is in use, the non-sour blue is usually used.

However, more and more hospital laundries are switching over to the combination of the sour and the blue operations, with economical costs and excellent results.

A typical example of this plan in operation is told by a Michigan hospital laundry manager using this method exclusively. He says:

"We use a sour blue immediately after the sour bath. The souring takes place rapidly and at a low level in about five minutes. We raise the water level to about 10 or 12 inches, add the blue, and run another five minutes. Sometimes, it takes a little longer with stain removal, but for a regular load ten minutes will take care of the work, allowing five minutes for the souring operation, five minutes for the bluing."

This increasing practice of souring at a low level and raising the level for bluing is so satisfactory that there is little reason to believe that this method for carrying out both processes in one operation will not give a high quality bluing.

As the quality of the work is not reduced, and the time and cost savings are obvious, this method is becoming more and more popular in hospital laundries throughout the country.

Although the hospital laundry is not plagued with the great variety of fabrics that confront the commercial laundry, some classification of fabrics will still increase the bluing quality for the hospital laundry work.

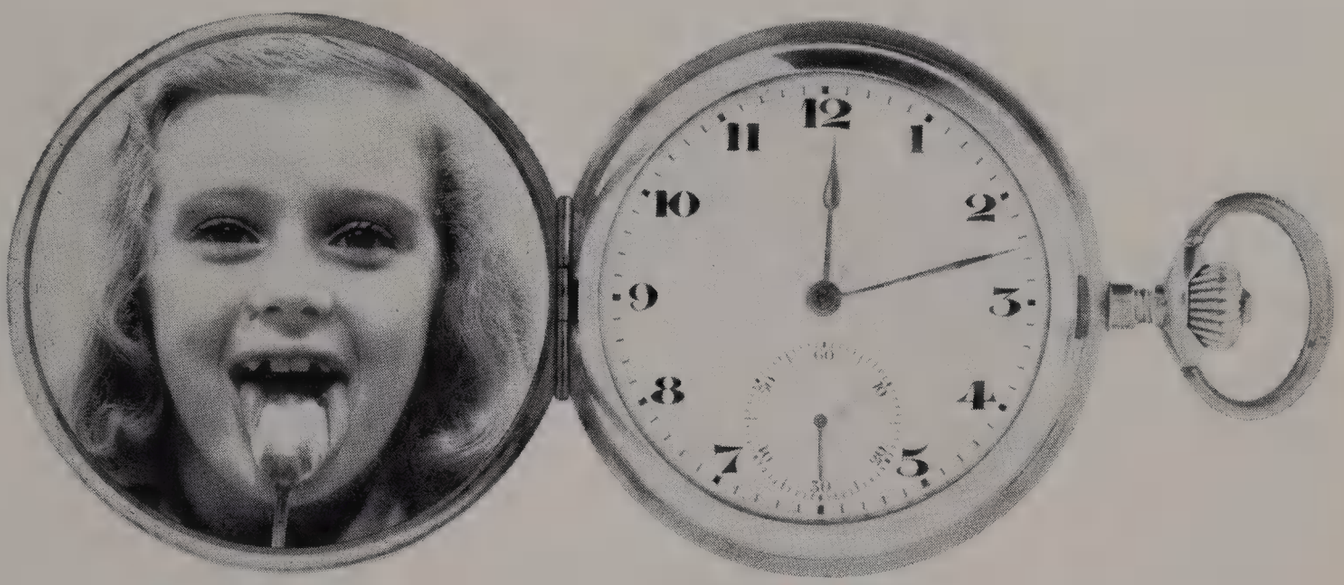
This classification for the bluing process will separate the new fabrics from the old, the more absorbent fabrics (such as bathtowels) from the harder woven fabrics (such as sheets). New fabrics and the towels tend to absorb more blue than the older fabrics and the less absorbent materials, and will result in blue spots and streaks if not classified.

A conservative estimate is that about 98 per cent of all bluing difficulties is caused by these factors—adding the blue unevenly, uneven souring, too little time for the bluing, a poor distribution of the blue along with the wheel, overloading the nets and the washers, uneven temperatures within the load itself, using too concentrated a blue, and failure to classify the fabrics.

Most of these bluing difficulties will not arise in a well-controlled washing process, and when these causes are reviewed they can be corrected and not allowed to recur.

This combined operation of souring at the low level, bluing at the higher water level will save time, labor, and cash while still producing a quality bluing work. The bluing process, as a finishing process, will make the white fabrics whiter, brighter, and more pleasing in appearance for every hospital laundry. ★

Streamlined antibiotic Rx for hospital services



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tempting, unusual
fruit and fruit-mint
flavors with no un-
pleasant aftertaste

fastest

ready to use
readily accepted
rapidly absorbed
rapidly effective

NEW broad-spectrum

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Each 5 cc. teaspoonful contains 125 mg. tetracycline plus a special vitamin formula recommended to meet the stress of infection.
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INTRODUCING HP's NEW

Housekeeping Department

by ANNE VESTAL ● Executive Housekeeper*

HELLO! I AM Anne Vestal, an Executive Housekeeper, and more specifically, the Executive Housekeeper who has joined the staff of HOSPITAL PROGRESS to write a column for Housekeepers, for *you.*

We're going to get together every month for a long time, I hope, via the pages of HOSPITAL PROGRESS, and since I already know quite a little about you (as you will discover pretty soon), it might not be amiss to tell you something about myself. Like many of you, I found it very hard, when first I started out, to get professional training for my work. Since there were no schools for hospital housekeeping, I learned hotel housekeeping and made adjustments on the job for the particular kind of guests we have in hospitals . . . the sick and injured. I went to institutes and short courses, and read just about everything in print that could affect housekeeping in its various aspects. Almost everything I have read has gone into a classified subject file.

Luckily, some years ago I was given the opportunity of teaching housekeeping. Do you, as I do, find that in teaching the teacher often learns more than the students? You just have to find answers for inquiring minds! When you have the responsibility for telling someone else *how,* you just have to be sure that your *how* is right. And then, since your student needs to learn things that will help her wherever *she* goes to work, and not simply in the given situation *you* know, you begin to evolve basic principles that can almost always be adapted to fit many, many, differing situations.

Are you wondering how I learned about you and just what you'd like to read about? A questionnaire was sent to 750 hospitals, and after your nearly 300 responses were tabulated, I knew quite a lot about you and your problems. The answers came in every mail, from every state in the Union, plus one response each from Alaska and Canada. (Questionnaires are still coming in, so we cannot as yet offer a report on the exact percentage of response, and almost all figures will have to be revised upwards.) Some of the results of the tabulation were illuminating, all were extremely interesting. Would you like to hear just what the study so far has shown? Here's the response classified by status in the hospital:

Executive Housekeepers	82
Administrators	155
Asst. Administrators	10
Personnel Directors	10
Others	29

Most responses indicated a general interest in housekeeping; more than a third had a specific interest in having housekeeping personnel absorb nonprofessional duties from other hospital personnel more generally (and more expensively) assigned to those duties.

Here's the run-down on immediate problems; remember now that each figure represents this number out of nearly 300 who answered:

Determining proper work load	161
Obtaining reliable information	137
Scheduling	135
General room care	126
Staffing problems (many aspects)	122
Floor care	102
Making control forms	92
Window care	90
Building ■ housekeeping library	83
Care of specialized areas	75
Supplies	67
Equipment	65
Decoration	64

There have been 14 institutes on housekeeping given under auspices of various organizations. These institutes seem not to have filled the bill for our Catholic hospitals, probably by reason of difficulty in traveling to the site of the institute. This assumption is borne out by the following figures:

Strong interest in support of regional institutes	186
Some interest in support of a national institute	35

I know you will forgive my seeming cynicism when I say that folk are *very* sincere when they offer to contribute money out of pocket to support a program. We are very sincere indeed, since 37 administrators and housekeepers indicated that they would contribute funds for making of films for training housekeeping personnel. Further, six others stated they *might* contribute, or would be glad to do so if they could afford to and the sum was not beyond reason.

It appears to me that the greatest single contribution that could be made to the field of hospital housekeeping lies in making simple, easy to follow, instruction films on the common housekeeping procedures, and one comprehensive film tying all the procedures together in one film on terminal cleaning of a patient room.

This is how we stand on the kind of articles you would most like to see in HOSPITAL PROGRESS:

Topical articles dealing with your 13 main problems	111
A related series of articles	207
A question and answer column	180

Running a related series of articles would mean that some of you would wait a year or more until we reached the topics of most interest to you. How does this plan appeal to you? Let us all get a copy of standard cleaning procedures, so we have a common denominator with which to work. (A "Manual of Standard Cleaning Methods" may be obtained for $1.50 from The American Hospital Association.) Then we will take up your 13 problems in the order of the greatest frequency as determined by the foregoing tabulation.

We will have, as often as space permits, a question and answer column. I will, for a trial period of two months, undertake to send personal answers to folk having emergency problems.

Well, now we know each other a little better. We know in what direction we are headed. Let's go! See you next month! ★

*Mrs. Vestal occupies this position at Jewish Hospital, St. Louis, Mo.

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2 USE PROPER TOOLS. Maintenance tools that are worn, or unsuited to the purpose will increase unnecessary labor, using even the best materials. Hillyard equipment that is "right" for each specialized maintenance operation can simplify methods—save hours in daily treatment.

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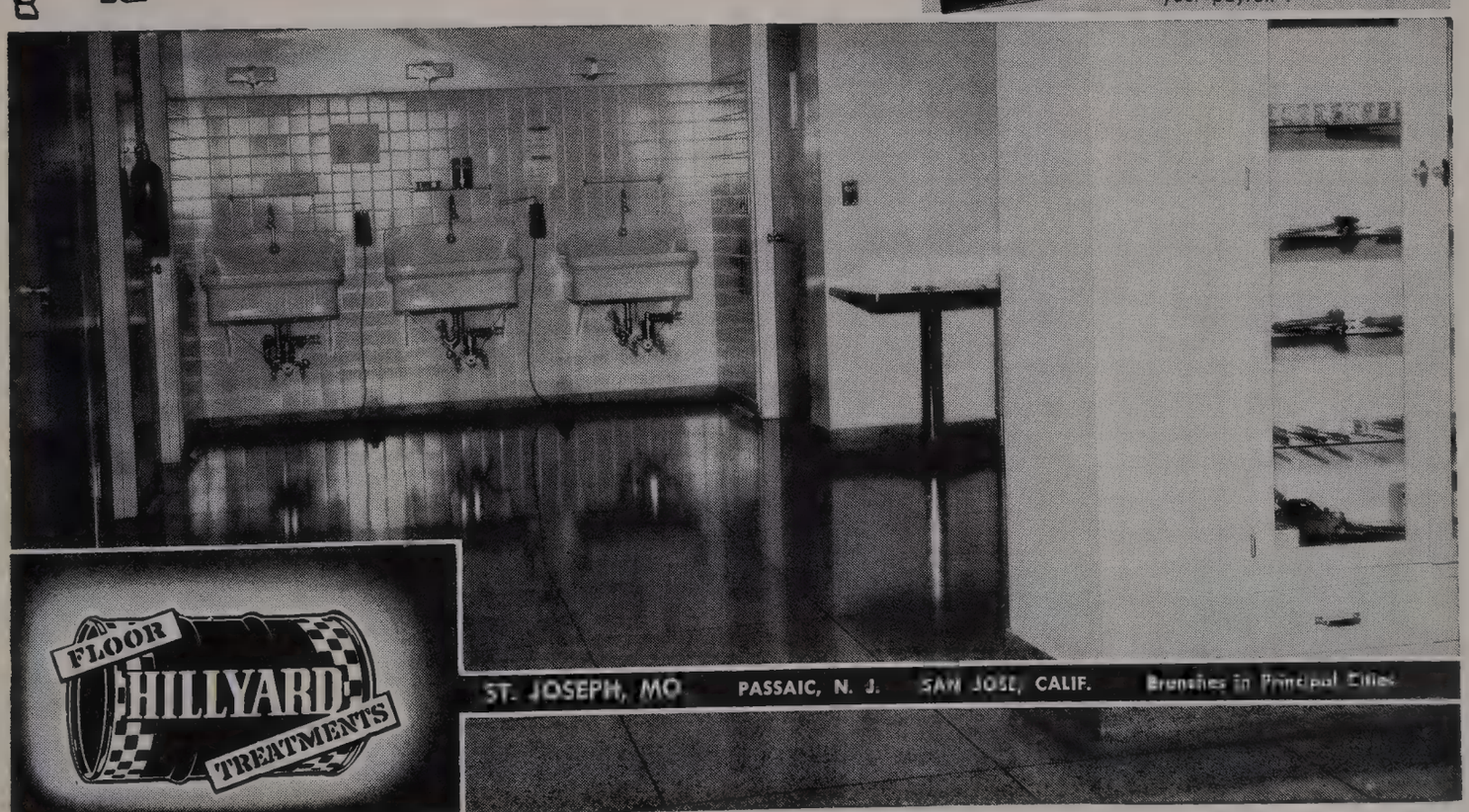

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Workshops Give Basics + Applications

by SISTER CHARLES ADELE, S.C.N., A.S.C.P., A.S.M.T.
Chief Medical Technologist ■ St. Vincent's Infirmary, Little Rock, Ark.

OUR MINDS are like a clock. We have to keep winding them up —by using good books, good readings, good information." Bishop Sheehan made this statement in one of his recent television talks, in which he exhorted his listeners to not let any opportunity pass which can serve to keep the mind alert.

An opportunity did pass for many technologists who could not or did not avail themselves (for one reason or another) of the Instrumentation and Standardization Workshop held at Louisiana State University, November 23-26, under the direction of Dr. Rudolf Muelling, Jr., associate pathologist of Charity Hospital, and director of the Standardization Laboratories at L.S.U. The course was held in the medical school division, where there are spacious classrooms and laboratories. The time was chosen because the school facilities could not be made available except during a vacation period of the students (in this instance, the Thanksgiving holidays).

The 44 registrants were continuously inspired by the interest, enthusiasm and co-operation of Dr. Muelling and his faculty. The workshop was excellently planned to give the enrollees not only a review of basic techniques, but also directives on putting basic knowledge into use in the individual laboratory.

"You don't know you don't know." Such a statement proves to be very true in the life of a medical technologist who does not endeavor to keep up with the laboratory advances of modern medicine. Unless a technologist reads and keeps informed, she does not necessarily even *hear* of such terms as electrophoresis, paper chromotography, the fractionation of proteins, etc., much less *realize* that within a very short time, the clinical laboratory will be called upon to give clinicians results of such determinations as mentioned above. Unless a laboratory is equipped with proper instruments and competent personnel to perform the technical aspects of laboratory medicine, the whole hospital is prevented in giving the potential *total* patient care that modern medicine requires of para-medical members of the hospital team.

Administrators are faced with educational problems in every department of the hospital—they must "keep up." The clinical laboratory, particularly, calls for constant building up in physical facilities, in acquisition of approved equipment for instrumental analysis, and in providing an alert pathologist-technologist team which can interpret and actually perform the tests needed for adequate clinical diagnosis and prognosis.

No other department is changing as much as the laboratory, and in order to keep up with current trends medical technologists must avail themselves of post-graduate instruction. The national societies of pathologists and technologists, the universities and doctors are well aware that advances in medicine could be furthered if there were adequate technical help, and such societies are thereby providing various workshops for graduate technologists. How important it is, then, that the ones in this field *do* keep up, so that *quality* is available even if quantity is not!

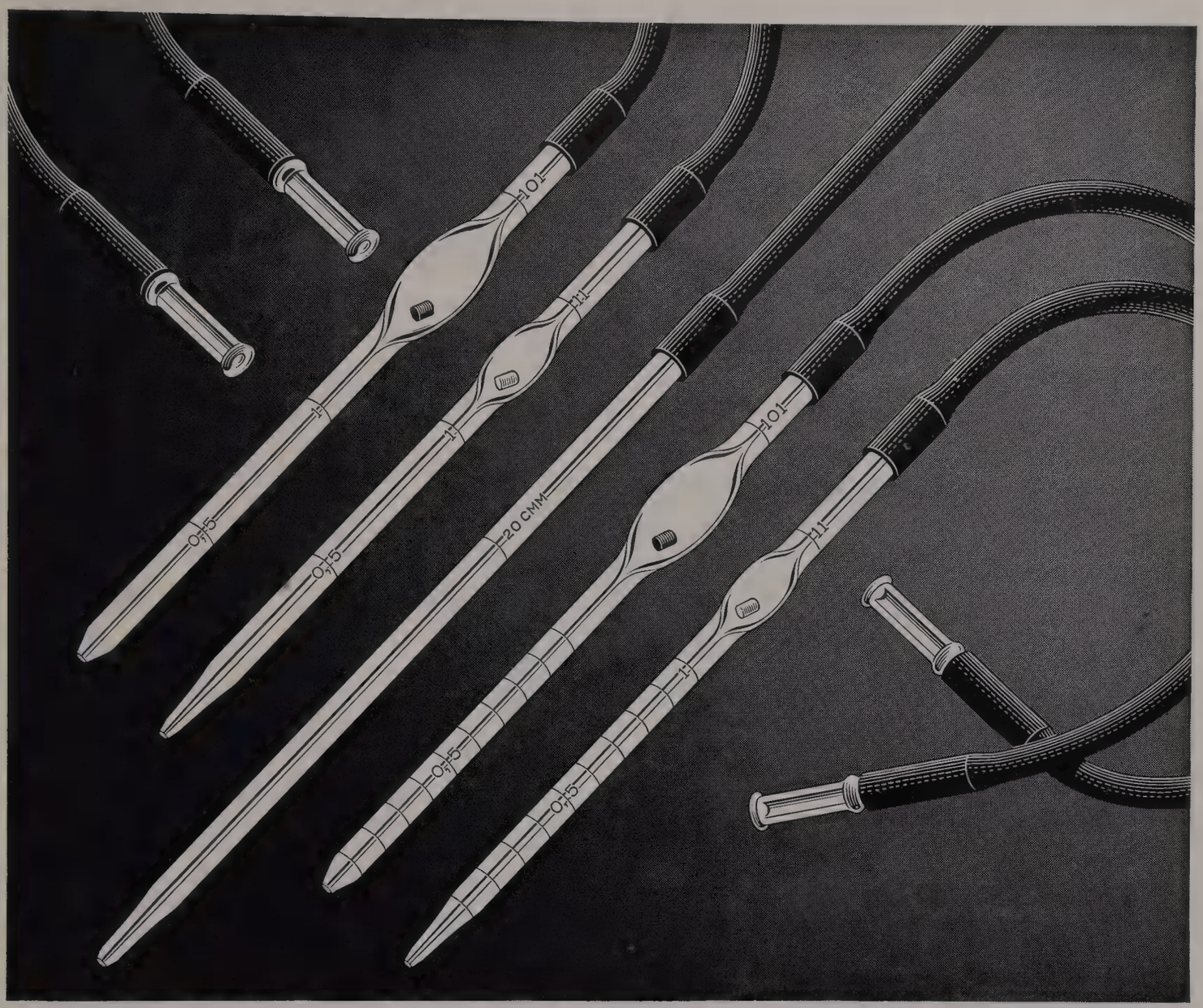
The Medical Technology Committee of the Catholic Hospital Association considers as one of its gravest responsibilities, the organizing and presentation of workshops in which the *personnel of the laboratories* of its member hospitals may avail themselves of opportunities to achieve as much accuracy and ability as possible within the scope of instruments available and of the time allocated to work. Technologists will render great service to this committee and (through them) to the Catholic Hospital Association, if they make known the channels by which laboratory information can be disseminated by the Association within their own hospitals. It is the intention of the committee to include help for the laboratory needs of every hospital, no matter what its size, location or physical make-up.

It is impossible to present without expense workshops of such a nature as the most recent one. It is logical to assume that fees for laboratory work-

PHILADELPHIA DAY-RATES

A. C. Eglin, Jr., C.P.A., the Hospital Council's accounting associate, analyzed Daily Charges and Beds per Room for 48 voluntary general member-hospitals, with total capacity of 11,788 beds. Median day-rates for medical and surgical facilities were: 1-bed, $17.00; 2-beds, $12.50; 3-4 beds, $11.00; 5-7 beds, $10.00; 8 beds or more, $10.50. Proportions of beds for medical and surgical cases were: 1-bed, 17%; 2-beds, 25%; 3-4 beds, 18%; 5-7 beds, 11%; 8 beds or more, 29%. Generally speaking, there are fewer beds per room outside Philadelphia.

[From: *News Letter* of the Hospital Council of Philadelphia]



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111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

CLINICAL LAB
—Sr. Charles Adele

(Continued from page 80)

shops, involving classrooms, *and* laboratories, *and* instructors, *and* equipment must be greater than those held for departments for which instruction needs can be satisfied in a single classroom. It is also logical to assume that the location of a city must be considered more than for its proximity to a majority of participants. Even though distances are encountered, the committee and C.H.A. must pick a location where a university can provide a time, adequate space, standard equipment and qualified instructors.

Technologists should be trained to *think* a problem all the way through. The committee therefore asks your indulgence in the matter of location of institutes. It is well worth a few extra hours of travel, and a few extra dollars, to spend the little time available for the acquisition of additional laboratory skills and knowledge in the most profitable manner. We are certain that administrators understand this reasoning, and medical technologists should make them aware of the excellent workshops being presented throughout the country by the Catholic Hospital Association, by the national and state societies, and by private universities. Substitutes can be found in some way for the few days' absence involved, and the whole hospital benefits by the competent practice and continued progress of laboratory medicine.

To return to our workshop instructions—twelve subjects, in a two-hour period each were presented in the following subjects: Chemical Calculations, Statistics and Laboratory Control, Spectrophotometry, Standard Solutions, Calibration of Glassware, Chromotography, Flame Photometry, Hemoglobinometry, Colorimetric Technique, Paper Electrophoresis, Protein Determination and Fractionization, pH and Potentiometric Titration.

These topics were each presented by, first, a discussion of principles and techniques involved and, second, by actual work in the laboratory. The techniques were so worked out that procedures requiring much time (such as heating, precipitating, and chemical development) were so arranged that the work could be done leading up to this point, and then continued by using an already completed procedural solution or other substance.

In this way, even though any one subject could not be *completely* treated, it was treated adequately enough for the student to understand the methods and principles, so that the entire subject could be reviewed in the student's home laboratory. After this 24 hours of actual classwork, one additional hour was allowed for questions and specific problems. A syllabus of from 4 to 8 pages was provided for each participant at each lecture, to which the student added her own notes.

This collection of twelve syllabi was itself worth the course, and the perusal of them will help each participant to profit for many a day from the few days spent at L.S.U. The syllabi are so organized and planned that help can be derived from them by any laboratory worker, regardless of experience and educational background. The inexperienced found help, and the experienced found help —which not only included new ideas on new topics, but better ways of presenting and understanding basic laboratory principles.

(Continued on page 85)

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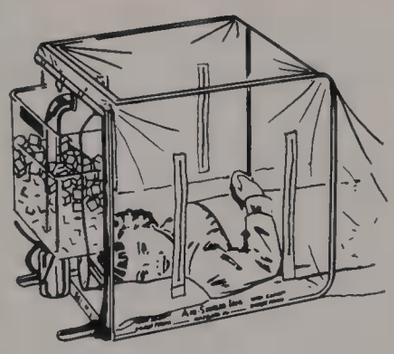
PATIENT COMFORT AND SAFETY FEATURES

	CROUPETTE	*Tent "A"*	*Tent "B"*	*Tent "C"*	*Tent "D"*
1. Recirculation of tent atmosphere	Yes	No	Yes	No	No
2. Cooling	Forced circulation	Convection only	Convection only	No cooling	Convection only
3. Free of interior obstructions	Yes	No	No	No	No
4. Ice chamber and drain inaccessible to patient	Yes	No	No	No cooling	No
5. Pressure connection inaccessible to patient	Yes	No	No	No	Yes
6. Water supply inaccessible to patient	Yes	No	No	No	Yes

CONVENIENCE AND NURSING FEATURES

	CROUPETTE	*Tent "A"*	*Tent "B"*	*Tent "C"*	*Tent "D"*
1. Quick and easy set-up and disassembly	Yes	No	Yes	No	No
2. Access to patient	Four side zipper openings	Down from top only	Down from top only	Down from top only	Down from top only
3. Filling of ice chamber	Outside	Inside	Inside	No cooling	Inside
4. Refilling of water supply	Outside	Inside	Inside	Inside	Outside
5. Mist apparatus integral part of tent	Yes	No	Yes	No	No
6. Storage compactness	Yes	No	No	No	No



3,000 hospitals and 96 per cent of all U.S. medical schools have 1 to 36 CROUPETTES in use, providing cool vapor therapy—with or without oxygen—for pediatric patients.

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Calculations for Chemical Pathology

The understanding of any given complete equation was emphasized. Short-cuts are allowed in some instances, but not unless "the chemist understands the full long method, because without modification many short-cuts have no flexibility." Solutions, derivations of formulas, definitions, gas laws and gasometry, standard conditions, Boyle's Law, Charles's Law, Avogadro's principle had a part in this discussion. Problems were solved and references for further study were included.

Basic Statistics and Laboratory Control

"Scattergrams" and "skewness" were two terms technologists added to their vocabulary and their use explained in statistics and laboratory control. "In chemical pathology much of our time is spent in the measurement of magnitude of chemical constituents found in submitted specimens. We must concern ourselves with the random or variable error, over which we have no control, *but* we should know the magnitude of the variable error in *any* test because this variance in measurement will be present in *all* measurements which are made."

We must learn to arrange the data we obtain in a usable manner, grouping it so that a class interval is derived. We should be certain that all technologists performing a procedure are thoroughly familiar with it. We should check the ability of each technologist to do replicate pipettings. *All* glassware should be calibrated. Use standard glassware. Random check the calibration of standard glassware.

All of this enters into laboratory control in addition to properly made standards, the use of blanks, the deviation of Beer's law for any given procedure, instrumental error, and calculation error. Additional checks are made by running auxillary standards. It is very helpful to check the accuracy of a laboratory's work by graphing the values of a given test for 1 week, 1 month, or 3 months. Most tests should show a mean which is within the normal range.

"Laboratory control is actually meticulous attention to small details, with frequent checking of standards, etc. Statistics help in technique of this control and serve to help the alert technologist to better monitor the values placed on the patient's chart."

Spectrophotometry

Participants reviewed the principle that all spectrophotometers have in common a method for diffraction, a means of selecting the proper wavelength of light and screening the unwanted light, and a means of measuring the absorbency. The visible spectrum was explained and demonstrated, and spectral-transmission curves were set up and interpreted. Actual graph plotting helped the student to visualize, graphically, the representation of the portions of the spectrum which are transmitted and those which are absorbed. Today, common custom plots the smaller wave-length to the left and the large to the right, using the per cent transmission as the ordinate.

Enough material was given in this session to devise, adapt and modify tests to the use of a given laboratory. "One reads a test at a specific wavelength because that is best according to the spectral-transmittance curve, and the density-concentration curve indicates a linear relationship at that point and *not because* the cookbook says to read it there. The 'cookbook'

may be wrong. Judicious use of this material allows the chemist to read at a different wave-length if interference from bilirubin and hemoglobin is a factor. It allows him to weigh the factors of interference against decreased sensitivity."

Basic information makes the chemist master of the test, and not the reverse.

Standard Solutions

No words of mine can express the approach to this topic as simply and effectively as the opening paragraph of the syllabus written by Dr. Muelling. "Standard solutions are the fulcrum of the chemical pathology laboratory. Great care must be exercised in the preparation of standard solutions as the accuracy of a test is predicated upon a properly prepared standard. No procedure can exceed the accuracy of the standard to which it is compared. Terrific pipetting and fancy calculations cannot compensate for a poor standard."

It was brought out that in making solutions, unless the expense of a particular chemical is involved, such as silver nitrate, it is more accurate to weigh *larger amounts* on a trip balance, and *dilute* down to the proper concentration.

Calibration of Glassware

What should one calibrate? Sugar tubes, N.P.N. tubes, graduated centrifuge tubes, burettes. Spot checks should be made on Normax or Exax pipettes. These are standard pipettes—no pipette not bearing the name of the manufacturer should ever find a place in the clinical laboratory.

Glassware designed for use with viscous liquids, blood, plasma, etc., should be calibrated with these fluids and those designed for aqueous solutions should be calibrated with these. For real accuracy, determinations should be done in triplicate or quadruplicate.

Paper Chromotography

Techniques have been developed in the last year whereby paper choromotography can be used in the chemical laboratory to identify urinary sugars and study amino acid patterns. The advantages of chromotography are its simplicity, adaptability and inexpensiveness. It is expected that simplified techniques will be developed for other applications in the clinical laboratory.

The principle of paper chromotography is this: "... the separation and identification of substances by paper chromotography is dependent on the different relative solubilities of each substance in water (stationary phase) and an organic solvent (mobile phase) which is immiscible or saturated with the water. The water has an affinity for the cellulose fibers of ordinary filter paper, and the paper therefore acts as an inert support for the stationary aqueous phase."

Satisfactory chromatograms can be successfully produced using simple laboratory equipment, such as test tubes, measuring cylinders, Petri dishes and dessicators. A variety of glassware may be used as chromatographic chambers, as long as the basic requirement of a reasonable airtight container and method for equilibration is observed.

Flame Photometry

The intensity of light is measured in flame photometry. Filters, prism and slit are used to screen all but one very narrow band of emitted light, which

(Continued on page 88)

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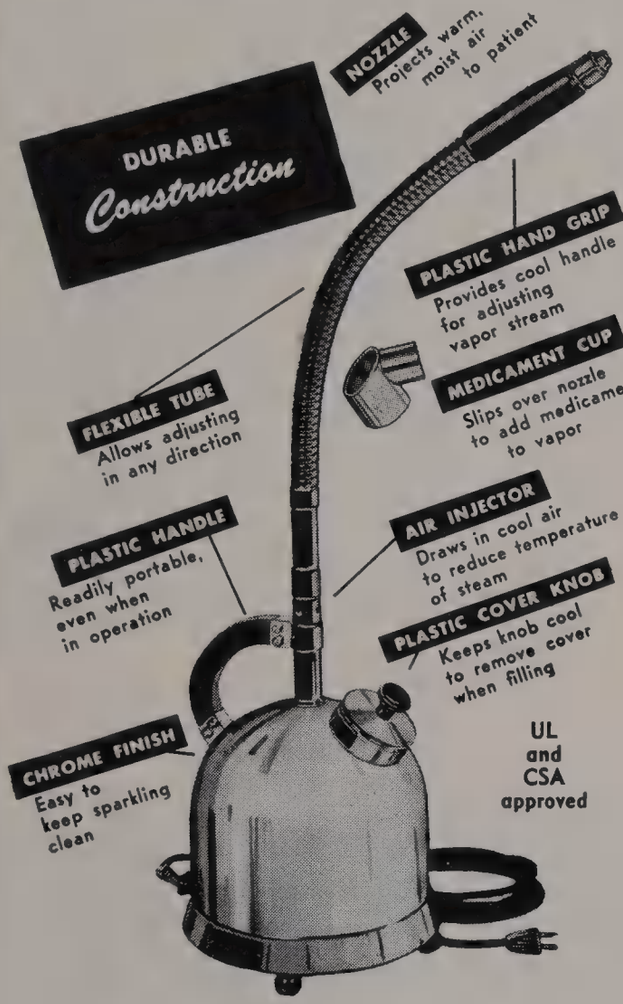

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It is not necessary to use a cone or croupe hood except in extreme cases. The flexible hose allows easy adjustment of vapor stream, thus allowing the patient maximum movement.

The Myrick Inhalator operates 10 hours on one filling, and vaporizes over one pint per hour. It cuts off automatically if it runs dry. The chromalox heating element gives lifetime service.

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CLINICAL LAB
—Sr. Charles Adele

(Continued from page 86)

may be measured. Comparison with a known standard gives the concentration of the unknown.

It was emphasized that particular care must be paid to the purity of the chemicals used in making the primary standards, which should be made up accurately and stored in plastic bottles. Unknowns should not be run until the blanks and standards read reproducibly for several successive times.

Hemoglobinometry

One gram of hemoglobin contains 3.4 mg. of iron and will combine with 1.36 ml. of oxygen. By the use of these figures, the actual hemoglobin content of the blood can be ascertained and the instrument factor calculated from the optical density of the whole blood.

All the difficulty in reporting hemoglobins may be resolved by reporting of hemoglobin in grams per 100 ml. of blood. The normals (Miller) are

Male 14 - 18 g % - mean 16 g %
Female 12 - 16 g % - mean 14 g %

"All standardization *must be done* with *calibrated glassware* and the *wave length setting* of the instrument used must be checked."

One method of performing hemoglobin iron content was done by the class, which measured the iron present in a measured amount of whole blood. Digestion of whole blood is accomplished and then color developed. The hemoglobin concentration was determined by a method of oxyhemoglobin.

Reminders by the instructors were frequent that standardization procedures must be carried out with meticulous accuracy. The instrumental hemoglobin factor must be check at reasonable intervals. Remember, particularly, *that every time something changes in the spectrophotometer—a new factor must be calculated.*

"To use any test in your laboratory you should determine the following as a minimum:

1. Spectral—absorbency curve
2. Density—concentration curve
3. Deviation point of Beer's law
4. Standard deviation of replicate standards
5. Percentage recovery of added known
6. Proper dilution for the sensitivity of available instrument
7. Normal range
8. Reproducibility

Precalibration is impossible for the accurate chemist. Only the use of a standard, where available, run every time the test is run, satisfies the general equation derived from Beer's law. The *density* of the unknown allows the calculation of the concentration of the unknown, *only because of its relativity* to the *density* and *concentration* of *standard."*

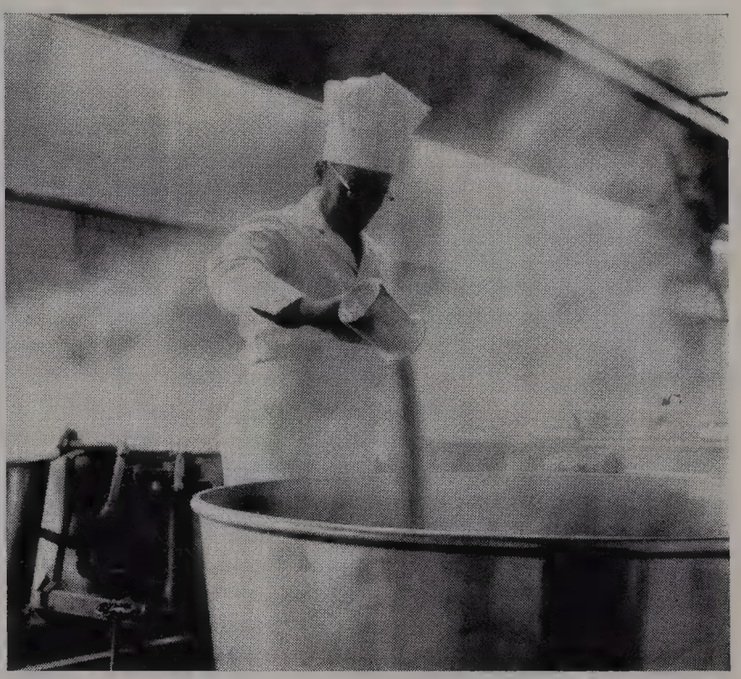
Filter Paper Electrophoresis

The principle of this phenomena is that "electrophoresis depends on the migration of charged particles, and their migration provides a qualitative and quantitative method of study."

A complete description and exhibit of equipment used at L.S.U. was made available. A "running" was performed and each student given a sample of the separation of proteins, dyed with amidoschwarz 10 B.

(Continued on page 90)

HOW HEINZ KETCHUP GETS ITS CAN'T-BE-COPIED FLAVOR



1 To get tomatoes good enough for Heinz Ketchup, we had to develop our own private strain on our Heinz experimental farms. Here they're checked to make sure they were at the peak of ripeness when picked.

2 The spices are weighed and blended, following Heinz secret, time-tested formula. The vinegar and sugar are carefully and accurately measured in. The onions, mild Californians only, are added.

3 We take our time cooking it down—for you can't rush good ketchup. And the results in batch after batch—thick, deep red and savory—are assured by Heinz know-how. The skills of our 50 years of ketchup making can't be matched overnight.

4 Make sure the can't-be-copied flavor of Heinz Ketchup is working for you. Served as a condiment or cooked into the dish, Heinz does more for food than any other ketchup. For the difference it makes, the cost is trifling. Order the famous 14-ounce bottle or #10 tin.

HEINZ 57 KETCHUP

YOU KNOW IT'S GOOD BECAUSE IT'S HEINZ

CLINICAL LAB
—Sr. Charles Adele

(Concluded from page 88)

Protein Determination and Fractionation

Since the determination of proteins is one of the most frequent orders received by the clinical laboratory, this discussion was one of the most interesting. Various techniques were discussed and illustrated, and we performed the Biuret method. The Biuret reagent reacts with certain groups to give a color reaction. The Biuret reagent is Ellerbrook's modification of the Weichelsbaum reagent. The fractionation of proteins was demonstrated also by the Biuret technique, and we were reminded that the development of electrophoresis gives a tool whereby the actual content of the fractions can be checked and measured on a densitometer.

The determinations by the method of Ellerbrook gives the following information:

1. Total protein
2. Serum albumin + Alpha b globulin
3. Serum albumin
4. Serum Alpha globulin (=2-3)
5. Serum Beta globulin + Gamma globulin (= 1-2)
6. Serum globulin (= 1-3)
7. Gamma globulin
8. Serum Beta globulin (= 5-7)

pH and Electrometric Titration

We quote again from the syllabus: "The hydrogen ion concentration, like that of the sodium and chloride ion activity, varies with concentration." The practical application is as follows: If you were to calculate the amount of salt and acid necessary to produce a given hydrogen ion concentration and were to mix these together in *exact* amounts, the hydrogen ion calculation would be *exactly* the calculated amount if and only if the ingredients were at unit activity. The pH instruments on the market were described and demonstrated. A graph was prepared by taking serial pH readings during the titration of a solution.

With this lecture ended a most successful workshop with every single participant delighted and awed with what had been presented—presented in such a way that knowledge had really been acquired in a useful form.

On Thanksgiving evening, the entire group had Thanksgiving dinner together at the Jung Hotel. On Saturday afternoon, the group—due to the thoughtfulness of Mr. Christopher of the C.H.A. Central Office had the pleasure of a quick tour of the city in a sightseeing bus.

The registrants are grateful they were the recipients of such a well planned course. Those who did not come, missed a wonderful experience.

To the Catholic Hospital Association, which made the course possible, to L.S.U., and to Dr. Muelling and his faculty, so interested and courteous, we owe a real debt of gratitude. And we are grateful, too, to the New Orleans Society of Medical Technologists, which gave us the inspiration to request this course. "Seeing was believing" at the National Convention, A.S.M.T.—and this longer and well-organized course was the result. *Deo gratias!* ★

Mississippi Catholic Hospitals Elect Officers

NEW OFFICERS and program participants at the annual meeting of the Mississippi Catholic Hospital Association are shown in the photograph at right.

Seated (l. to r.) are Sister Mary Camille, Meridian; Sister Mary Emmeline, Meridian, president, and Sister Mary Noel, Vicksburg, vice-president.

Standing (l. to r.) are Frank J. Buchanan, U.S. Adjustor of Claims, Meridian; Rt. Rev. Msgr. J. B. Brunini, director of Catholic hospitals of the Diocese of Natchez; and Miss Mavis Phillips, Jackson.

For a fuller account of the proceedings, readers are referred to "This Month With the Association" in this issue.

"SRO" Sign Already Out for NEHA's 33rd Meeting in 1956

NOT UNTIL BOSTON builds a convention hall-hotel project, such as has been on the drawing boards for some time, will the New England Hospital Assembly be able to accommodate all the hospital personnel who want to attend NEHA sessions.

The SRO (Standing Room Only) sign has been hung out each year for the past four years.

Last year more than 6,000 persons attended the NEHA sessions, taxing the capacity of meeting rooms, lobbies and exhibit facilities. The 33rd Annual session, scheduled for March 26, 27, 28, 1956, is expected to attract an even larger number of registrants. Every available inch of space will be needed at the Statler Hotel to accommodate those who will attend either the general sessions or Instructional Conference meetings, a new feature added last year, according to Richard T. Viguers, administrator of the New England Center Hospital, Boston, NEHA President.

The Instructional Conference Sessions, which attracted 2,849 applications in 1955, are being expanded for 1956. Already inquiries are being received from hospital line-staff personnel, requesting priority, even though the catalogue of lecture courses available will not go into the mails until mid-January.

William S. Brines, administrator of Newton-Wellesley Hospital, NEHA Exhibit Manager, set a deadline of December 5th for exhibitors' applications. Applications on hand on that date exceeded the space available in the grand ballroom, lobby foyers and function rooms on the mezzanine and a new exhibit area in sample rooms on the fourth floor, added last year. Priority is given to exhibitors on the basis of the number of consecutive years they have participated. A long waiting list exists.

William E. Sleight, administrator of Roger Williams General Hospital, Providence, R. I., 1956 Program Chairman, has held several meetings of program planners since early fall and is aiming at January 15 as the target date for the general session program to go to the printers. Every effort is being made to plan for and hold all meetings within the Statler Hotel, although program committee members are frank to admit it may be necessary to hold some meetings outside the hotel if the demand continues. ★

In line early last year to register for the 1956 NEHA instructional conferences were Sister Annunciata and Sister Mary Mercy, both of Mercy Hospital, Portland, Me. It proved a wise precaution, as the accompanying story suggests.

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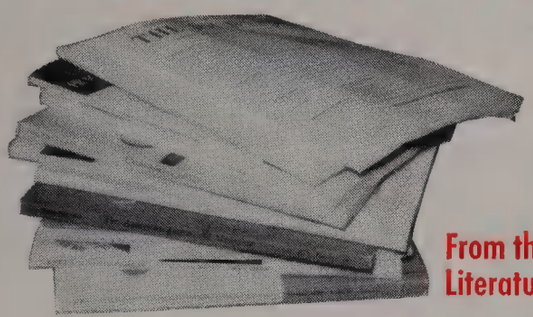


From the Literature

"It is difficult to fail to be impressed with a drug which like penicillin, or cortisone, has an almost accurately predictable and unfailing effect, and which is capable of revising pathological changes of long standing."[1]

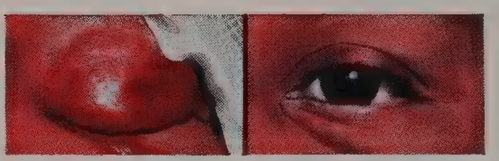
"It (intramuscular trypsin) is effective in extraocular trauma, uveal tract inflammation, in anterior and in some posterior chamber hemorrhages of recent origin."[2]

"A salutary effect on the thrombophlebitic process was elicited. The per patient hospital stay averaged 19 plus days for those not receiving trypsin, against 9 plus for those who did receive it."[3]

Direct anti-edema, anti-inflammatory action has many applications in the wards, emergency rooms and outpatient clinics.

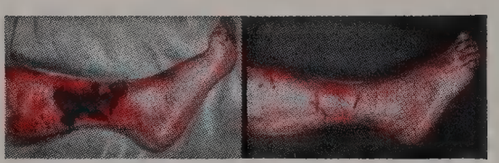
Advantages of PARENZYME, *Intramuscular Trypsin:*

- Safe method of administering parenteral trypsin; no major side effects; not anticoagulant
- can be used in conjunction with any other therapy prescribed
- early ambulation and return to full activity
- no metabolic derangements such as often occur with other anti-inflammatory agents
- known amount of active enzyme is used
- tends to enhance use of antibiotic therapy



Deep laceration left eyebrow. Penicillin administered, condition worsened, marked edema, pre-auricular adenopathy, pain.

Antibiotics plus Parenzyme administered. 24 hours improvement. 48 hours eye opened. Rapidly healing.



Female diabetic, 72 years old. Peripheral arteritis obliterans, with cellulitis and gangrenous ulcerations. Burning pain.

Parenzyme administered daily. Healing of ulcer complete. Pain and edema eliminated.

Time between photos 9 weeks.

INDICATIONS: The cardinal indication for Parenzyme is acute inflammation regardless of etiology.

TRAUMATIC WOUNDS: slow-healing wounds, bruises, contusions, black eyes.

SKIN ULCERS: decubitus, varicose, diabetic.

VASCULAR DISORDERS: phlebitis, thrombophlebitis, phlebothrombosis.

OPHTHALMIC: iritis, iridocyclitis, chorioretinitis.

The film, CLINICAL ENZYMOLOGY, is available for showing at all hospital meetings upon request.

DOSAGE: 2.5 mg. (0.5 ml.) intragluteally q. 6 h. until improvement results; q. 12 h. thereafter. RECOMMENDED METHOD OF INJECTION: Very slowly intragluteally.

SUPPLIED: 5 ml. multiple-dose vials (5 mg. trypsin/ml.)

REFERENCES: 1. Wildman, P. J. Intramuscular Trypsin in the Treatment of Chronic Thrombophlebitis, Angiology, Oct. 1955. 2. Campagna, F. N. and Hopen, J. M., Trypsin in Ocular Disease. Delaware State Medical Journal, 27, March 1955. 3. Seligman, B. Clinical Experience with Trypsin, Ohio State Medical Journal, 51, May 1955.

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Re TV: Whether it's RACKET SQUAD or ROCKET SQUADRON, an escapist tendency is more apparent than an esthetic one.

★

Few are lonelier than one in a hospital bed.

★

Scudding clouds over rain-swept roofs and dripping autumn boughs remain . . .

BOOKS RECEIVED

ESSENTIAL OF PEDIATRICS
By Philip C. Jeans, F. Howell Wright, Florence G. Blake. Philadelphia: J. B. Lippincott Company. 5th ed., 1954. $4.75.

GERIATRIC NURSING
By Kathleen Newton, R.N., M.A. St. Louis: C. V. Mosby Co. 2nd ed., 1954. Pp. 424: illus.

INTRODUCTION TO PHYSICS IN NURSING
By Hessell Howard Flitter, R.N., M.A. St. Louis: C. V. Mosby Co. 2nd ed., 1954. Pp. 288

MODERN SCIENCE AND GOD
By P. J. McLaughlin, D. es Sc. New York: Philosophical Library. 2nd Impress., 1954. $2.75

THE TRUTH ABOUT CATHOLICS
By Virgil A. Kelly. New York: The Dial Press. 1954. Pp. 173; $2.75

THE STUDENT AND THE MATCHING PROGRAM
Prepared by the National Intern Matching Program. Chicago: 1955

DISEASES OF THE HEART AND BLOOD VESSELS
Prepared by the American Heart Association. New York: Rev. Ed., 1954. Pp. 16

MOTHER CATHERINE McAULEY—A GREAT SOCIAL WORKER
By Sister Mary Isidore Lennon, R.S.M. St. Louis: 1954. Pp. 111: illus.

THE CHALLENGE TO MEDICAL EDUCATION
By Robert M. Cunningham, Jr. New York: Public Affairs Committee. 1954. Pp. 28; illus., $.25

A GUIDE TO HOSPITAL BUILDING IN ONTARIO
Prepared by the Committee on Designing, Constructing and Equipping of Public Hospitals in Canada. Toronto: Toronto Press. 1954. Pp. 307; illus., $10.00

THE HEALTH INSURANCE STORY
Prepared by the Health Insurance Council. Chicago: 1954. Pp. 63; illus.

THE EXTENT OF VOLUNTARY HEALTH INSURANCE COVERAGE IN THE UNITED STATES
Prepared by the Health Insurance Council. Chicago: 1954. Pp. 31; illus.

STANDARDS FOR GENERAL CONVALESCENT HOMES CARING FOR CARDIAC CHILDREN
Prepared by the American Heart Association. New York: 1954. Pp. 20

DIAMOND WASHROOM DIGEST
Prepared by the Diamond Alkali Company. Cleveland: 1954. Pp. 15: illus.

YOUR FUTURE AND YOU
Prepared by the Metropolitan Life Insurance Company. New York: 1954. Pp. 17; illus.

EMOTIONS AND PHYSICAL HEALTH
Prepared by the Metropolitan Life Insurance Company. New York: 1954. Pp. 10; illus.

LAW OF CONSENTS

—Ludlam

(Continued from page 67)

by letter, telegram or the like. However, this is an area in which strict legalism should be tempered with reason, and consideration should be given to the nature of the procedure involved. Surely it is logical to argue that a parent placing a child in such temporary custody has at least by implication authorized the custodian to take all reasonable steps for the preservation of the child's health and welfare. This would take care of the usual treatments for colds, protective shots, cuts and the like, but would not include elective procedures such as cosmetic surgery or radical treatment of various conditions.

If we are applying the rule of reason we should obtain a logical result. We should, of course, obtain the written consent of the custodian, the camp counselor, the dormitory supervisor, foster parent or the like, as well as that of the child, as this will be consistent with our contention that these persons have the authority of the parents, either express or implied, to do whatever is in the best interests of the child. Perhaps there is some risk, but the risk is slight and one that can be properly assumed by an organization dedicated to the care of the sick. For elective surgery and the more radical types of treatment, we should make every effort to obtain the consent of the parent in advance, and the hospital records should clearly reflect the efforts made in this regard.

(H)—Persons in the custody of the law can create a real problem. For example, the use of blood samples to determine drunkenness has become increasingly accepted. In California several of our law enforcement authorities have taken the position that they have the right to take blood samples, either by authorizing the hospital technician to do so, or by bringing a police technician into the hospital to do so. We have taken the firm position that the voluntary hospital has an implied duty to protect its patients from such an assault and battery and must not permit this without the consent of the patient. By consent we mean one given by him when he fully realizes what he is doing. If the police want to take blood without the consent of the patient then they must take the patient into custody and remove him at their own risk to a government hospital.†

The police problem may have an entirely different facet. A minor boy or girl may be in the custody of the law. Here there can be no implied consent by the parents, so we take the position that unless it is an emergency we must have the consent of the parent and not that of the police officer or head of the reformatory.

(I)—In discussing the problem of consent we are constantly faced with the claim of some doctors that the child is emancipated and therefore can consent to his own treatment. Some states do recognize the doctrine of emancipation and permit a minor who is no longer in the care, custody and

(Continued on page 97)

†Our opinion has had at least one rather unfortunate consequence. A police technician got so mad at the hospital doctor for refusing to permit this act that he struck the doctor. This, however, does not change our conclusion, and under the recent decisions of the United States Supreme Court on the subject of illegal search and seizure, we will continue to advise hospitals not to permit such activity.

MEDICAL RECORDS —Johnson

(Concluded from page 65)

red my prediction of the outcome; i.e., the histologic grade.

The third and final step was to correlate my prediction of the outcome with the actual outcome of the case. This was done by construction of a correlation table such as that shown in Table I. My prediction is shown as histologic grade, and the actual outcome in five-year survival rates.

ENDOMETRIAL CARCINOMA STAGE I

GRADE	NUMBER	RATE
I	25/42	60%
II	19/29	65%
III	1/4	25%
	45/75	60%

TABLE I. Relation of five-year survival rates to histologic grade of endometrial carcinoma.

When the skeptic looks at Table I he can say: "I told you so." The only figure that really suggests a prediction is the low value of 25 per cent for the "bad" tumors (grade III). For the other two grades, the difference is not only quite small, but in the reverse direction from that expected. The "good" tumors do slightly worse than those in between. When one notes that the 25 percent is based on a series of four cases, it is fair to say that this particular investigation failed to yield convincing evidence that a pathologist can predict the outcome by looking at the histologic section when he is deprived of all clinical information. The skeptic may be right.

The Methods

Our immediate concern, however, is not with the results of the investigation, but with the methods by which the items of information were obtained. We noted three principal steps in the description : (1) obtaining the group of records with which we planned to work; (2) recording the data on individual cards, and (3) summarizing the data through correlation tables. The individual cards and the correlation tables are the responsibility of the investigator alone.

At our hospital, a coding system has been worked out that fits the specialized case material with which we deal. There are four major subdivisions in our system:

1. Calendar year
2. Malignant or benign lesion
3. Anatomic site
4. Pathologic lesion

The first two categories are dictated by the special nature of our case material. Since we are greatly interested in the outcome of the case, and since the outcome does not always become apparent for many years, it is important that the calendar year in which the diagnosis was made be included in our code. This avoids the unnecessary task of having to sort out from the group for investigation those cases that are too recent for assessment of the outcome. The second category is also of great assistance in narrowing down the number of pages in our code that the librarian must search through to obtain her record numbers.

The third and fourth categories are based, of course, on the Standard Nomenclature of Diseases. We have amplified both of these categories to suit our special purposes and we occasionally alter the wording just a little bit to include common phrases used by the medical staff in discussing cases.

The fourth category, as applies to malignant lesions, is divided three times. The first division is based on presence or absence of previous treatment before coming to our hospital. The second is based on the clinical stage or extent of the disease, and the third, on the histologic type as revealed by the pathology report.

All three divisions have been found to be very useful in the delineation of the group of cases for an investigation. The system has been in use now for four years and up to the present we have had no real difficulty in finding the cases for the investigator, while holding to a minimum the extra cases that he must sort out and discard. To illustrate how it works, the order from the investigator to the librarian for the cases in the study which I described could be written as follows:

Years 1940-1948
Malignant-Benign ..... Malignant
System ..... Female Genital
Organ ..... Endometrium
Histologic type .. Adenocarcinoma
Previous treatment ..... None
Clinical Stage ..... All Stages

In conclusion, a clinical investigation is a joint project in which the librarian serves as a prospector seeking the gold-bearing ore while the investigator is the refiner who extracts the pure precious metal. The end product is that most precious of all commodities, human knowledge. ★

(Continued from page 95)

control of his parents, and who is sufficiently mature to make a reasoned judgment, to consent to his own treatment. We have no decisions in California, and would be inclined to predict, in view of our specific statutes on the subject, that the court would not recognize this doctrine. Hospitals in other states will have to find out the law on this subject from their local attorneys.

(J)—If we cannot obtain an express consent we may still be able to furnish the necessary medical care if it is an emergency. Here again is a subject that is not subject to any fixed definition. Some authors use the broad statement that the treatment must be necessary to save the life and health of the individual. Such a definition is hard to apply. Here again it appears we should use a rule of reason and it would seem that this is a two step process.

First, it is necessary to determine the treatment immediately required and necessary to prevent deterioration or aggravation of the patient's condition. This may be a matter of first aid or temporary medical care in lieu of surgery, or actual surgical or orthopedic procedures.

Second, the hospital must assess the possibilities of obtaining the necessary consent, weighed against the possibility that a delay to obtain this consent would jeopardize the health of the patient. In other words, the hospital must attempt to follow a conservative course, constantly keeping in mind that once it has undertaken to treat such a patient it must follow through in a reasonable manner under all circumstances

If the doctor or hospital is relying on the doctrine of emergency, great care should be taken to record the circumstances on the patient's record, and if possible there should be consultation, which in turn should appear on the record over the signature of the doctor called in for consultation. In such consultations care should be taken to obtain the opinion, if possible, of other doctors who have actually examined the patient.

The doctrine of emergency applies equally to the patient who is unconscious, as it does to the minor child.

(K)—Occasionally we have a situa-

tion in which some persons assert the right to deny care to a patient for reasons of religious belief, or personal conviction against the particular treatment. This situation is always dangerous, and prudent practice requires a prompt call to your lawyer to pass on the particular circumstances. In our experience we have, on occasion, had to advise several different courses of action because of varying factual situations.

If the person has the legal right to give consent, then that person has the right to withhold consent, and we may be helpless even in an emergency. If the right exists in two persons, such as the mother and father, and they are not in agreement, then in emergency cases we usually advise that at least first aid treatment be given. If no emergency exists, we prefer to let the court decide. As a last resort we do require that the matter be referred to a guardianship proceeding with the ultimate decision being left to the court.

(L)—Whenever possible, the consent should be in writing, although oral consent is binding, even though it is often more difficult to prove. If it is necessary to rely on an oral consent, then every precaution should be taken to establish further the fact of the consent. The circumstances and names of witnesses should be recorded. If taken by phone, it should be double checked by placing a second person on the line, as well as requesting the consenting party to confirm by telegram.

Most consent forms provide for a witness, and much confusion has arisen over this requirement. There is no legal requirement that the consent be witnessed. However, the witness may be of vital importance if at a later date the signature to the consent is questioned. Suppose the patient claims that she was mentally incompetent at the time of the signing, or that she had no opportunity to read what she was signing. In that event the witness can be produced to refute this claim and recount the facts. Such a witness need not be a registered nurse, but some competent employee of the hospital available for future testimony.

Another matter often overlooked in the recording of a consent is the condition of the patient. A consent may be invalid if the patient did not realize what he was doing when he signed the consent form. For this reason we recommend that the exact time of the taking of the consent be recorded to void a later claim by the patient that he was under opiates when the consent was taken. This may be critical when the patient's chart indicates that he received a strong sedative about the time the nurse claims the consent was taken. Several years ago a trial turned on this very issue and the data recorded on the consent established that it was taken before the administration of the opiate to the patient.

Although I have attempted to be fairly complete, I am sure that the month will not pass without some alert hospital medical record librarian calling with a new combination of circumstances that do not quite fit within the rules set forth above. Then, maybe we will find a decision on the subject, maybe we will be forced to resort to the "rule of reason," but in any event we will bless the day that these girls were trained to protect the best interests of the patients and the hospitals. It is not easy to say "No" when some illustrious staff member is impatiently demanding to proceed with a scheduled surgery. ★

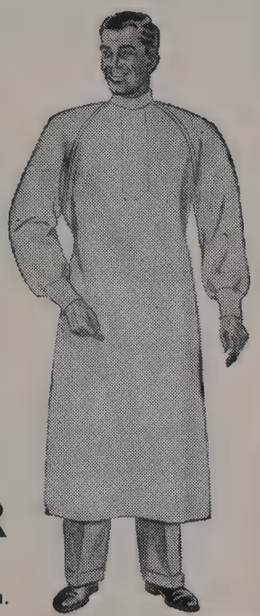
Celebrating OUR 52nd YEAR

IN THE HOSPITAL APPAREL FIELD

As a result of zealous devotion to our task, our 52nd year finds us in the enviable position as a leader in the production of hospital apparel . . . a leader in products of quality, style, comfort and durability.

YOUR INQUIRIES ARE INVITED

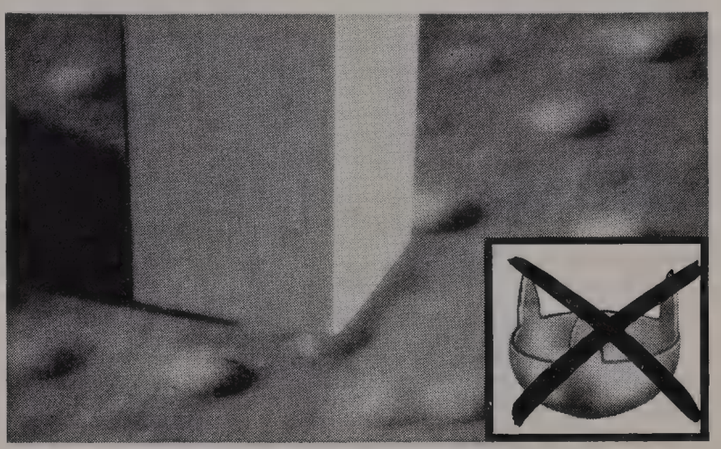
Hospitals frequently require a special type of binder, drape, sheet or garment to suit a particular problem. Sometimes a doctor needs a tailor-made uniform or it may be a type of patient requiring a certain binder or other garment not available as a stock item. Many hospitals have contacted us with their problems and more and more depend on Kuttnauer speed and economy. Let us assist you in this department as well as in your regular requirements.



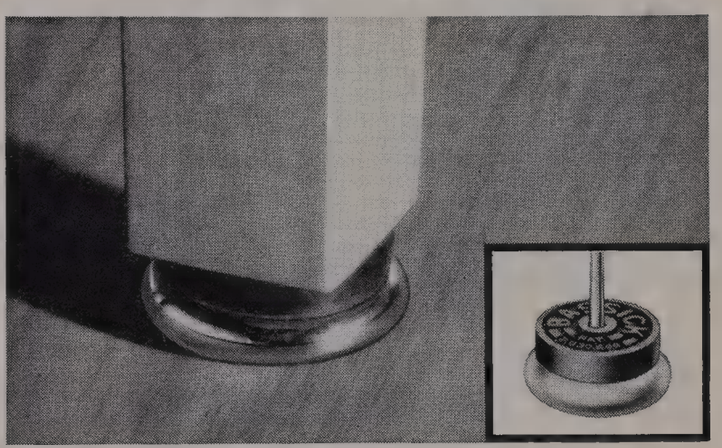
KUTTNAUER
MANUFACTURING CO.
2189 Beaufait Ave., Detroit 7, Mich.

Send for latest Catalog—No obligation

A case of floor pox!



Its cause



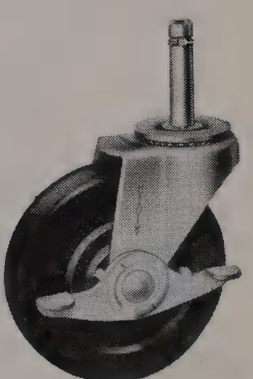
...and remedy

When floors break out in a rash of pock marks, the cure is usually expensive. You either repair or replace!

Stop floor pox before it starts by equipping chairs and tables with Bassick's Rubber-Cushion Glides. Their broad, flat, hardened-steel base distributes furniture weight evenly over a large area. They slide at a touch without leaving unsightly trails. You can adapt them to either wood or metal furniture.

QUIET, PLEASE!

There's no quieter or easier way to move hospital beds, tables, screens and service carts than on Bassick's "Diamond-Arrow" casters. Whisper-quiet in action, they roll at a touch and swivel easily. Soft rubber treads will not put a pox on floors. Send for copy of Catalog HPF-54 today. THE BASSICK COMPANY, Bridgeport 2, Conn. *In Canada*: Belleville, Ont.



Bassick
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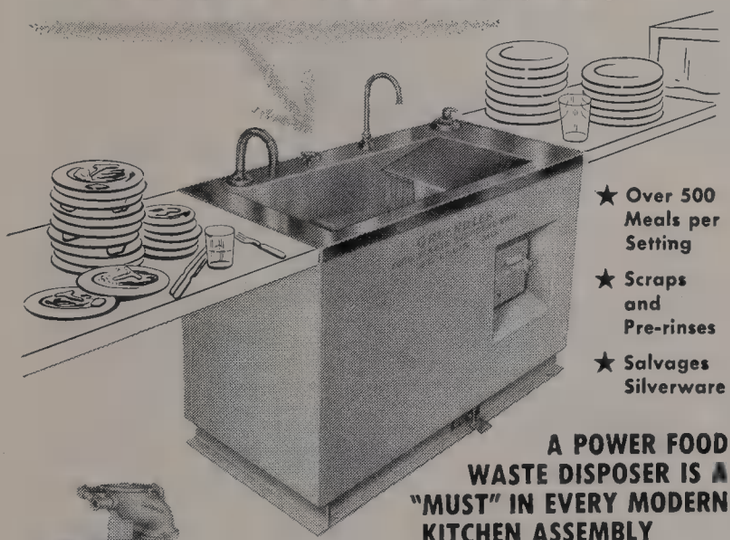
MAKING MORE KINDS OF CASTERS... MAKING CASTERS DO MORE

PUT YOUR FOOD WASTE PROBLEMS *DOWN THE DRAIN!*



★ Over 500 Meals per Setting
★ Scraps and Pre-rinses
★ Salvages Silverware

A POWER FOOD WASTE DISPOSER IS A "MUST" IN EVERY MODERN KITCHEN ASSEMBLY

The Model G-400 Series in the Gruendler line of Food Waste Disposers is recommended for large Hospitals, Industrial Cafeterias, Restaurants . . . and for any and all Institutions where meal servings range from 500 to 2000 per setting.

MODEL C-150
Built to meet the food waste disposal needs of smaller Hospitals, Restaurants and Cafeterias serving up to 300 meals per setting. Available in 1½ and 2 H. P. complete with all necessary fittings for incorporation in existing kitchen assemblies.

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GRUENDLER
CRUSHER and PULVERIZER CO.
2915-17 North Market St. ST. LOUIS (6), MO.

New Supplies and Equipment

Remington Rand Roto-Kard

SPEEDING REFERENCE and lightening the work load in handling 8″ x 5″ record cards is now possible with Remington Rand's new space-saving record-keeping unit—the Roto-Kard.

The new Roto-Kard, with many outstanding improvements over ordinary drum record housing units, handles 8″ x 5″ card records for perpetual inventory records, ledgers, maintenance records, personnel records, etc., in one compact electrically- or manually-operated rotary drum.

Completely mobile for easy rolling to its point of use, the Roto-Kard has a capacity of 6,000 8″ x 5″ cards (9½ pt. stock) for a reference record or 4,500 cards for a posting record.

Occupying a floor area of only 3.6 square feet, the new unit has removable self-contained desk-tray segments for job distribution and peak load period handling. A Slide-A-Deck feature permits, for the first time on a drum file, the shifting of complete decks of cards between segments, without fear of misplacing or dropping.

Built to standard desk height, Roto-Kard eliminates excessive operator exertion and fatigue and maintains a high record-keeping efficiency. An easily removed linoleum-covered posting shelf for front mounting on the unit permits postings with a minimum of wasted motion. Provision is made for quick inserting and easy removal of individual record cards without card damage.

Complete description and specifications of the new Remington Rand Roto-Kard unit, for either manual or electric operation, together with all necessary accessories such as cards, guides, signals, etc., are described in a new folder—KD 770—available at Remington Rand sales offices in all principal cities or by writing the New York Office.

Remington Rand Division
Sperry Rand Corp.
315 Fourth Ave., New York, 10, N.Y.

Tomac Multi-Controller for Paralyzed Patients

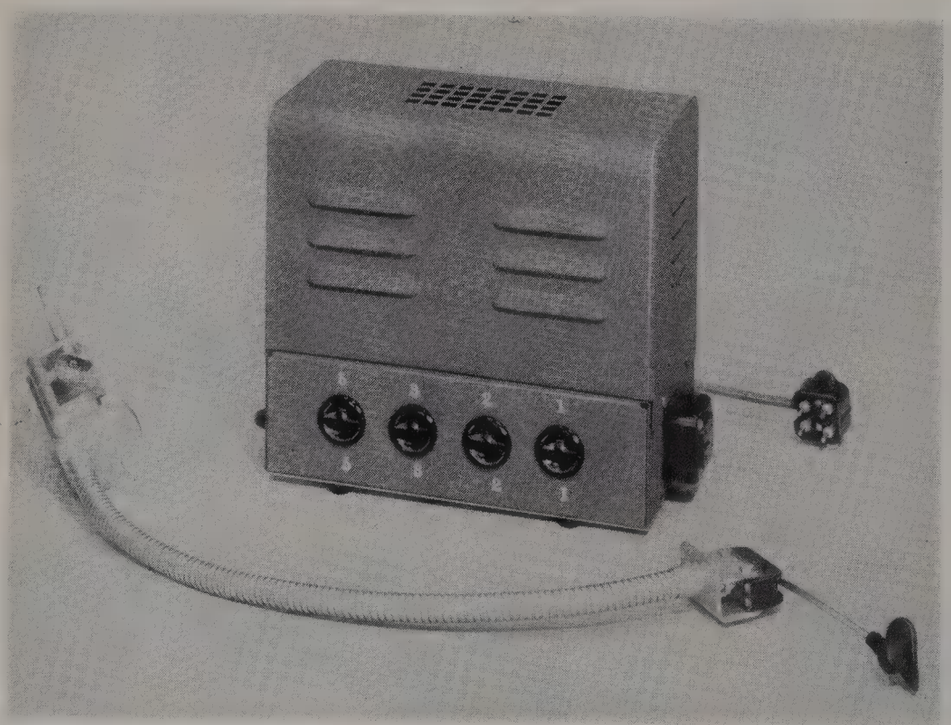
NEW FREEDOM OF ACTION, and new independence for paralysis patients are now possible with the Tomac Multi-Controller which provides an automatic touch control for buzzer system and any four other electrical devices. With a slight touch of one small switch, the fully dependent paralyzed patient controls any five electrical devices—separately or all together as he desires. The appliances are selected by a simple touch code the patient learns in a day—only an imperceptible movement is needed to bring on his radio or TV set, to signal for assistance or turn on a bed light; he can even use the telephone. This new independence can give an immense boost to patient morale, and cuts down immeasurably on the number of calls for patient care.

The appliances connected to the Multi-Controller can be operated individually or in combination. For example, the radio can be playing, and the patient may use the phone without interrupting the radio. The patient activates the appliance or appliances wanted by the number of touches and timing given the multi-controller switch. A different number of touches turns off each appliance.

The Multi-Controller itself is a simple device and requires no more care than a fine radio. Just plug in the electrical devices desired and the Multi-Controller is ready to operate. Multi-Controller consists of four outlets, built-in buzzer and micro-switch with gooseneck and clamp. If a telephone connection is included, the telephone company should be contacted for the proper instrument to be used with the Multi-Controller.

American Hospital Supply Corp.
General Offices
Evanston, Ill.

Tomac Multi-Controller for Paralyzed Patients



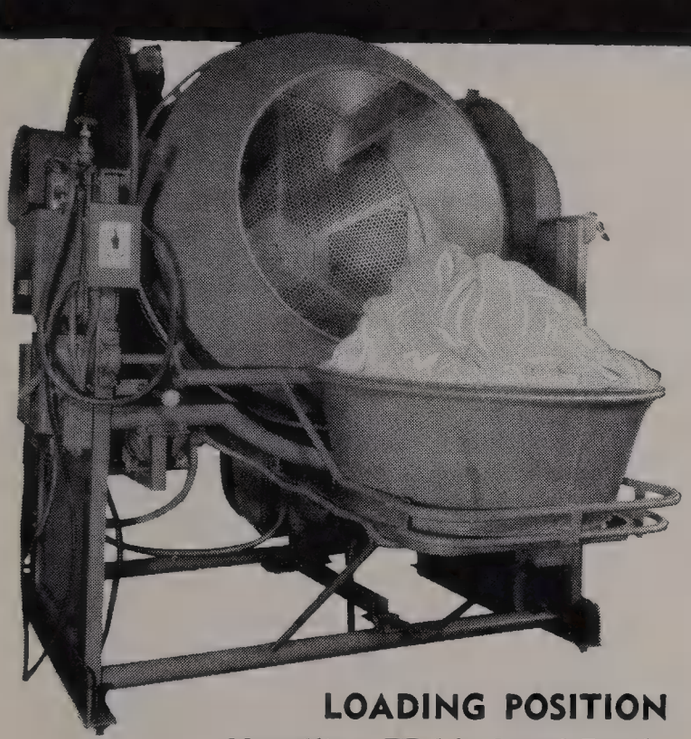
New Brochure Features Vacuum System Equipment

THE COMPLETE LINE of vacuum system equipment manufactured by the Ohio Chemical & Surgical Equipment Co. (A Division of Air Reduction Company, Incorporated), is featured in a new brochure, "Central Vacuum Systems" now available upon request.

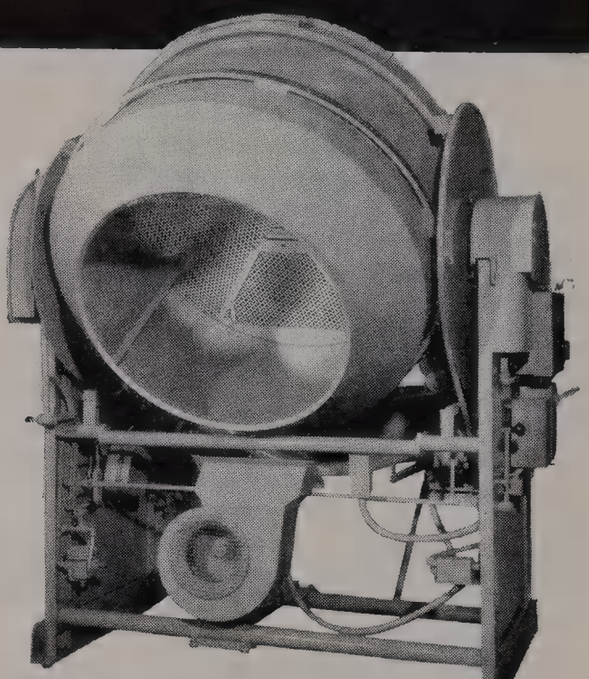
Major items of equipment described include Ohio Chemical vacuum pumps Simplex and Duplex models: a vacuum regulator and trap bottle; and a vacuum bottle and carrier on casters (floor model).

The Ohio Chemical vacuum bottle and carrier on casters, used with a wall mounted vacuum regulator and trap bottle, provides increased capacity for collecting fluids and furnishes an extremely fast, even action at low

You'll say *"It's amazing . . . even unbelievable"* . . . when you see how the new Purkett 48" "Pre-Dryer" conditions flat work and garments



LOADING POSITION
Handling 50 Lb. Load Easily



UNLOADING POSITION
Shows Powerful Blower

Especially for the 1-ironer plant where formerly only the 72" size was available with Pre-Drying

Affectionately called "BIGMOUTH" this equipment . . .

1. Will keep your ironers working full capacity with improved quality throughout.
2. Removes one gallon additional moisture in 5 minutes tumbling time.
3. Eliminates re-runs by removing excessive moisture and keeping remainder properly distributed.
4. Increases production with less labor by eliminating costly hand shake-out . . . employee fatigue reduced.
5. Pays for investment in 12-18 months.

These and more advantages described in the new file folder on the 48" "BIGMOUTH" . . . It's yours for the asking.

PURKETT'S CONSULTING SERVICE . . . A Purkett specialized engineer will consult with you on your linen and garment conditioning problems . . . without obligation to you.

Naturally it's a PURKETT

Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

PURKETT MANUFACTURING COMPANY
Joplin, Missouri
DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

vacuums. It also eliminates the danger of tearing delicate tissues—a possible result of the surging action of high vacuums. A bottle cap float assembly is optional equipment.

To obtain a copy of the new brochure, "Central Vacuum System," request Form 4677-B.

Ohio Chemical
1400 East Washington
Madison 10, Wis.

Hycel System by A.H.S.C.

ADAPTABLE FOR ANY LABORATORY, the Hycel System provides accurate, reproducible results for protein bound iodine determinations. The result of extensive research and testing by Hormone Chemistry Laboratory, Houston, Texas, the system affords a simplified, easy-to-follow method. Two sets are available. The complete set contains sufficient reagents for over 600 tests, and special equipment for performing 20 or more tests daily; 10 corroborative assays provided in the technical service. The small set contains reagents for over 200 determinations, and special equipment to perform several tests daily; technical service includes three corroborative assays. All reagents are tested, prepared and purified from selected stock. All equipment has been specially tested, designed or modified to strict Hycel specifications. In addition, practical, concise Manuals on Methods, Uses and Interpretations are supplied with each set.

Scientific Products
Division of A.H.S.C.
Evanston, Ill.

Abstract Available from Mallinckrodt

MALLINCKRODT CHEMICAL WORKS has prepared an *Abstract of Changes and Additions in the U.S.P. XV and N.F. X* for distribution to the drug and pharmaceutical industry and will serve as a convenient reference to users of both of these publications.

It contains a complete list of products admitted to the *U.S.P. XV* and *N.F. X,* which became official on December 15, 1955. It lists all products that appeared in the *U.S.P. XIV* and *N.F. IX* but were not admitted to the new editions. In addition, it indicates products transferred from the U.S.P. to N.F., and vise versa, and designates significant changes in products, titles, tests and specifications.

Copies of this booklet are available upon request from Mallinckrodt offices in St. Louis and New York.

Mallinckrodt Chemical Works
2nd & Mallinckrodt Sts.
St. Louis 7, Mo.

Hot Plate Server by Legion Utensils

A DRI-HOT PLATE which keeps food hot for as long as an hour and a half —using no electricity, gas, water or complicated gadgets has been introduced by Legion Utensils. The ready-to-serve china plate is set in a stainless steel holder, containing a preheated alloy core, and covered by a stainless steel plate cover. Write for a complete catalog.

Legion Utensils Co.
40th Ave. & 21st St.
Long Island City 1, N.Y.

Angelica Basic Uniform Available in Spring Green

ANGELICA UNIFORM COMPANY has introduced a new color, in its basic uniform. The all-purpose dress is now available in ten colors, making it pos-

sible for even large hospitals with many departments to follow the "one-style-several colors" plan. Fashioned of Sanforized Monte Cloth, the dress is coat-styled for easy changes. Princess lines make it adaptable to any type of figure.

For further information about this dress, or a catalog showing garments for all departments of the hospital, write the nearest branch of Angelica Uniform Company or the main office.

Angelica Uniform Co.
1427 Olive St.
St. Louis 3, Mo.

Ry-Krisp Bulk in New Caddy Pack

A NEW "HANDY SERVER CADDY" is now being used for shipping the eight pound semi-bulk institutional size of Ry-Krisp.

The "handy server" feature of the new box is an easily removed, replaceable snap lid. The "caddy" has a special interior coating which maintains freshness.

Ry-Krisp is also available in Individuals 180s (2 double-square wafers in a sparkling-fresh cellophane envelope).

Ralston Purina Company
Checkerboard Square
St. Louis 2, Mo.

Glassware Draining Rack by Scientific Products

A NEOPRENE RUBBER COATED STEEL WIRE glassware draining rack is now available from Scientific Products, Division of American Hospital Supply Corp. Occupying only 10½ inches x 15¾ inches of table or sink space, the rack will hold up to 14 pieces of glassware. Top shelf holds eight graduates, the middle is ideal for funnels of various sizes, and the bottom can be used for miscellaneous items. A rust-proof drain pan is included.

Scientific Products
Division of A.H.S.C.
Evanston, Ill.

Kodak Improves Verifax Copy Paper

AN IMPROVED PAPER for the Verifax Copies which almost doubles copies available from a single matrix has been announced by the Eastman Kodak Company, manufacturers of the photocopy machine.

Known as Verifax Copy Paper, the new product makes it possible to produce a minimum of five copies per matrix as compared to the three rec-

ommended for the paper previously available. Used with either letter or legal size Verifax machines, this paper reduces the price to 2½¢ per copy when five are produced.

Price of the new Verifax Copy Paper per 500 sheets is $3.95 in the letter size and $4.95 in the legal size.

Eastman Kodak Company
Rochester 4, N.Y.

Automatic Washer—40-45 Lbs. Capacity

AN ADDITIONAL LAUNDRITE WASHER MODEL of 40 to 45 lbs. capacity has been announced by Troy Laundry Machinery Division.

Referred to as the Laundrite "40," the new machine was designed with automatic operation similar to the popular 25-lb. model. Full range temperature control is provided through a selective thermostatic dial setting. Controls also provide automatic water level and cycle timing as well as dumping; yet the controls allow any change, at any time, by a turn of the dial.

A free bulletin is available.

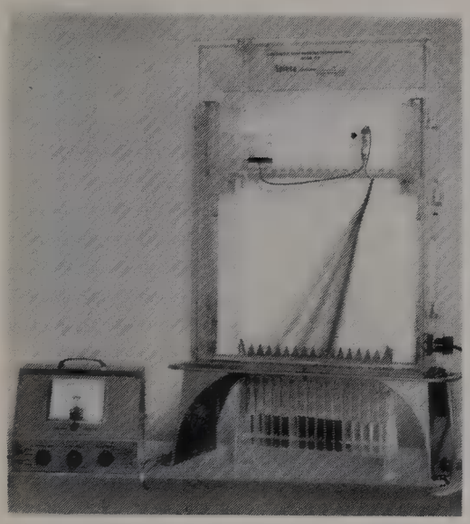
Troy Laundry Division
American Machine and Metals, Inc.
554-12th Avenue
East Moline, Ill.

Spinco Continuous Flow Paper Electrophoresis

IMPROVEMENTS OVER EARLY WORK in terms of flexibility and efficiency have been engineered into the new Spinco Continuous-Flow Paper Electrophoresis apparatus. New methods of electrolyte feed and wide-range controls permit the instrument to give maximum throughput under any required degree of resolution. At the same time, design efficiency has been raised so that resolutions formerly requiring as much as 1,500-volt operation are made at ⅓ this value.

Under test and evaluation in the Spinco research department for the past two years, the new unit is manufactured under U.S. Patent (No. 2,555,487). Applicable to the separation of all kinds of charged substances such as proteins, polypeptides, amino acids and other biological materials, the unit also handles such organic substances as dyes and intermediates. In special cases non-polar substances such as carbohydrates can be separated. The apparatus is also particularly useful for following organic reactions, and for immuno-chemical work.

Chief departures from previous practice include large-volume vertical



Continuous Flow Paper Electrophoresis

wicks between the curtain and electrode vessels to provide optimal distribution of the electrical field and at the same time prevent migration into the paper curtain of electrode products. Controls permit precise adjustment of feed point and positioning and orientation of the pattern. A specially-designed automatic fraction collector is available.

Paper-curtain electrophoresis offers the basic advantage that the processed material travels a unique path and thus adsorption does not interfere with the purity of the product. Because of this, absolute separations can be made. The new apparatus adds to this advatage the following features: it is easily assembled and disassembled for cleaning; paper curtains are quickly removable for oven drying in analytical applications; a wide range of types and thicknesses of curtains can be used; stability of operation permits unattended runs of indefinite duration; large samples can be processed at throughputs up to 8 ml per hour; small samples can also be processed with virtually no hold-up; a specially-desiged pump circulates buffer—or recirculates where desired, permitting location of reservoirs below the apparatus.

Spinco Division,
Beckman Instruments, Inc.
497 O'Neill Avenue
Belmont, Calif.

Telescopic Safety Sides by Tomac

SAFETY SIDES that telescope completely out of the way, reduce storage problems, and fit all standard beds, have been designed and engineered exclusively for American Hospital Supply Corp.

When not in use, Tomac Safety

Sides telescope and fold up (either at side or behind bed) so they can be left right on the bed ready for instant use, or stored away. Because the sides can be easily and quickly attached without tools, nurses find it a simple matter to change them from one bed to another, as need requires. Specially-designed holders allow Tomac Safety Sides to be fitted to all standard beds. When telescoped out of the way, they can't interfere with foot room, containers or other objects under the bed as do ordinary rails. Telescoping sections slide easily and smoothly. A rubber wheel bumper is fitted to upright section to prevent sides from marring walls when in position behind bed.

Tomac Telescopic Safety Sides, made of chrome-plated steel, are ruggedly constructed to give years of active service. Maximum extended length is 86 inches. The sides will fit all standard beds with springs of 80″ or less; fold up to 7½ inches. Maximum space between bars is 5 inches.

American Hospital Supply Corp.
General Offices
Evanston, Ill.

Pre-Drying Conditioning Tumbler

PURKETT MANUFACTURING CO. announces a new improved 72 inch Pre-Drying Conditioning Tumbler with such features as: A 12-inch coil producing 35 per cent more heating surface (optional to those wanting more heat than produced with the 9-ring coil); a larger (5 inch) blower; two 8-inch vents (optional or the regular perforated doors may be designated) for eliminating the "moisture and lint menace."

Tests have shown that with the new unit 20 per cent moisture content is removed in five minutes' tumbling time. Power tests at the boiler have shown that only 7 B.H.P. is used in its operation.

Free literature is available.

Purkett Manufacturing Co.
Joplin, Mo.

Truck for Oxygen Tanks by Colson Corp.

EASY ANO QUIET MOBILITY of oxygen tanks is assured by the sturdy little truck being introduced by The Colson Corporation. Its 19⅜″ over-all height permits it to be placed under the bed when not in use, and its 16¾″ wheel base assures stability.

The flat steel toe plate slips under the tank and the truck then is tipped back onto the 3″ rear swivel casters which are equipped with lock brakes. They have steel disk, rubber tire wheels. The large wheels are 8″ in diameter with replaceable cushion rubber tires. All tires are conductive rubber.

The frame, consisting of 1″ steel tubing, is finished in glossy, silver gray enamel. Over-all length vertical is 22″ and over-all length tilted is 25½″. Shipping weight of the unit is 27 lbs.

The Colson Corporation
Elyria, Ohio

Elasticon Mattress Protector

Mattress Protector by Continental Hospital Service

A RECENT RELEASE annouces a new, highly efficient mattress protector, Elasticon, fabricated from Continental's Plasticon, a hospital sheeting which can be boiled and autoclaves, and is non-combustible.

The design provides complete protection for the top and all sides of the mattress, and it is firmly held in place by re-inforced elastic bands, which pass under the mattress across each corner. It assures the "tailored" appearance, and provides soft, quiet comfort, as well as long-lasting protection of expensive bedding.

Continental Hospital Service
Cleveland (Lakewood) 7, Ohio

Roof Ventilator by American Machine

A NEW CENTRIFUGAL ROOF VENTILATOR has been designed by DeBothezat Fans Division for buildings where pleasing appearance and quiet performance are prime requisites.

Low in silhouette and distinctly pro-

filed, the ventilator is reported to move large volumes of air efficiently against static pressures at low speeds—and accordingly at low noise levels. Its large unit exhaust capacity is accomplished at low fan tip speeds by a backwardly curved non-overloading centrifugal fan wheel. The wheel runs in a venturi shaped inlet ring which further reduces air turbulence noise and increases operating efficiency.

Bulletin DR-40-55 is available free of charge.

DeBothezat Fans Division
American Machine and Metals, Inc.
East Moline, Ill.

Single Unit Patient Helper by Chick

THE NEW CHICK ANY-BED MONKEY BAR is the perfected single unit patient helper that solves many weaknesses of previous single units. The bar has a trapeze arm that swings to any bed position and locks to give a safe assist to patients in moving and to assist nurses in moving patients in and out of the bed.

The Chick Any-bed Monkey Bar embodies the principles employed in sound bed construction, namely, the locking together of all sides—top, bottom and both sides—for rigidity to prevent spreading, buckling, and to protect the bed from damage. Neat in appearance, compact, light-weight, simple in construction, the bar can be assembled quickly.

Gilbert Hyde Chick Co.
788 Ponce de Leon
Atlanta, Ga.

DePuy Featherweight Crib Fracture Set

A NEW LIGHT-WEIGHT CRIB FRACTURE SET, introduced by DePuy Manufacturing Co., Inc., is constructed of octagonal aluminum alloy tubing, which eliminates slipping, while affording light-weight and ample strength.

The manufacturer states that a nurse can easily and quickly assemble and attach the set to any metal or wood crib. Fastening and adjustment are speeded by the use of lever type clamps of exclusive DePuy design. The set, known as the No. 660 Featherweight Crib Fracture Set, is designed to take all types of traction for infants and children. All parts of the 18-lb. set are interchangeable.

Complete information may be obtained by writing the manufacturer.

DePuy Manufacturing Co., Inc.
Warsaw, Ind.

SUPPLIERS' NOTES

American Hospital Supply Corp.

George Blomquist has joined the New York division staff of the wholly-American-owned subsidiary, American Hospital Supply Export Corporation.

In his new position, Mr. Blomquist will assist Vice-President John Willman in sales promotion work of AHSECO, which is presently equipping the new 845-bed military hospital in Lima, Peru. He has been handling Federal sales work and other special assignments out of the company's Washington division.

American Laundry

New address of the Philadelphia Office of The American Laundry Machinery Company has been established at 18 Summit Grove Avenue, Bryn Mawr, Penn.

Baxter Laboratories

Raymond D. Hetterick has been appointed vice-president in charge of sales at Baxter Laboratories, Inc.

Mr. Hetterick was formerly executive vice-president of the Harrower Laboratory, Inc., recently absorbed as a result of the Warner-Lambert merger.

Fenwal Laboratories, Inc.

John G. Gibson, II, M.D., has been appointed consultant in research to Fenwal Laboratories, Inc., Framingham, Mass. A staff member of the Department of Medicine of the Peter Bent Brigham Hospital and Harvard Medical School, Dr. Gibson is also staff member of the Massachusetts Insttiute of Technology. He is a member of the American Society of Clinical Investigation and the International Society of Hematology.

The new general sales manager of Fenwal Laboratories, Inc. is Robert A. Schultheiss of Attleboro, Mass. Before coming to Fenwal he was for nine years with the Robbins Company, Attleboro, where he served as plant engineer and sales promotion manager. Prior to that he was a mechanical and sales course engineer with the General Electric Company.

The company has become the exclusive distributor of empty Upjohn bottles, caps, bands and wire handles used by hospitals which make their own infusions. An inventory of the Fenwal Automatic Venting Stopper for simple and convenient closure of Upjohn bottles is being maintained.

Distribution of the items was taken over by Fenwal Laboratories following decision of the Upjohn Company to discontinue its prepared infusion solutions.

Huntington Chair Corp.

A fourth showroom of the Huntington Chair Corporation has been opened to provide Florida dealers and decorators with a factory source of quality furniture to meet the area's expanding requirements for equipping institutional, resort and residential housing.

The 4,500 square-foot structure at 96 Northeast 40th St. Miami, has been designed for effective display of the over 170 patterns in the versatile Huntington line of furniture. A special feature of the permanent exhibit is a display of pre-built units which are delivered from the Huntington plant all ready for installation without further carpentry or finishing.

Johnson Service Company

To provide better service for its customers in northern New Jersey, Johnson Service Company, manufacturers of automatic temperature and air conditioning control systems, has moved its branch office in Newark to 1126 Morris Avenue, Union, N.J.

Landers, Frary & Clark

Mr. Arnold W. Bahder has been appointed sales development manager of the electrical housewares division of Landers, Frary & Clark. In his new position, he will be responsible for sales development of Universal electric housewares and also for Electresteem products manufactured by The Electric Steam Radiator Corp., a subsidiary of Landers, Frary & Clark.

Mills Hospital Supply Co.

Mr. M. D. Paynter has been named assistant to Mr. Irving Mills, president, on all sales matters in connection with a program of expanded sales activities.

Mr. Sol Singerman, former director of purchases of Michael Reese Hospital, Chicago, has been named general manager. He will concentrate his efforts towards developing the supportive services of Mills to meet supply needs as defined by hospitals in their efforts to provide the best possible patient care within the framework of scientific management.

Parke, Davis & Company

Dr. George M. Shadle has been appointed medical co-ordinator in the sales department of Parke, Davis & Company. For the past three years he has been a member of the company's clinical investigation staff in Pittsburgh.

Chas. Pfizer & Co., Inc.

Louis McFarland Timblin, treasurer and a director of Chas. Pfizer & Co., Inc., died after a heart attack. Mr. Timblin joined the Brooklyn drug and chemical concern in 1940 as auditor and subsequently became assistant treasurer. He was appointed treasurer in 1945.

The company has announced the following appointments:

Paul E. Weber has been named sales manager of the company's Chemical Sales Division. He succeeds Frank F. Black. Mr. Weber was appointed assistant sales manager at the Brooklyn N.Y. headquarters in 1954.

Sam G. Brock is the company's new Southwestern regional manager for Pfizer laboratories, division of Chas. Pfizer & Co., Inc. His office will be in Dallas, Tex.

Neil A. Morton, branch manager of Pfizer Canada since 1952, was named executive assistant to Mr. McGoodwin in New York.

Fraser W. Lockhart, formerly Canadian pharmaceutical sales manager, was promoted to branch manager and general sales manager, Pfizer Canada.

Philip Lindsey, formerly Canadian chemical sales manager, was named branch manager, Pfizer Canada.

H. Chandler Smith, eastern regional manager for the past three years, has been assigned to the division's headquarters staff as assistant to Paul E. Weber, assistant sales manager.

John E. McVeigh, former manager of the food and beverage department, succeeds Mr. Smith as Eastern regional

manager. Succeeding Mr. McVeigh is Jack D. Langlois, who has held the position of assistant manager in the division's medicinal chemical department since June, 1952.

Robert D. Campbell joins the division's mid-Western region as a sales representative.

Robert A. Bittner, formerly district manager in Atlanta, has been appointed Southeastern regional manager. Mr. Bittner will supervise Pfizer Laboratories sales activities in ten southern states and the District of Columbia, and will continue to make his headquarters in Atlanta.

William J. Welling has been appointed to succeed Mr. Bittner, and Fletcher Spann will take over Pfizer Laboratories sales in the Birmingham, Ala. district. Mr. Welling was formerly associated with Pfizer's sales training department in New York while Mr. Spann was a special hospital representative in the Baltimore area.

Francis A. Walsh has been named as a pharmaceutical marketing analyst of the Market Research Department of Chas. Pfizer & Co., Inc.

Raybestos-Manhattan, Inc.

William A. Michie, sales manager, Revolite Division, Raybestos-Manhattan, Inc., N.Y., recently announced the appointment of Frederick Y. Peters to the Revolite staff.

Mr. Peters has been in the laundry business for a number of years and is well acquainted with all its phases, having served as production and sales supervisor, as well as manager. He will work with William H. Sullivan and William Bering in Pennsylvania, Southern New Jersey, and Western New York.

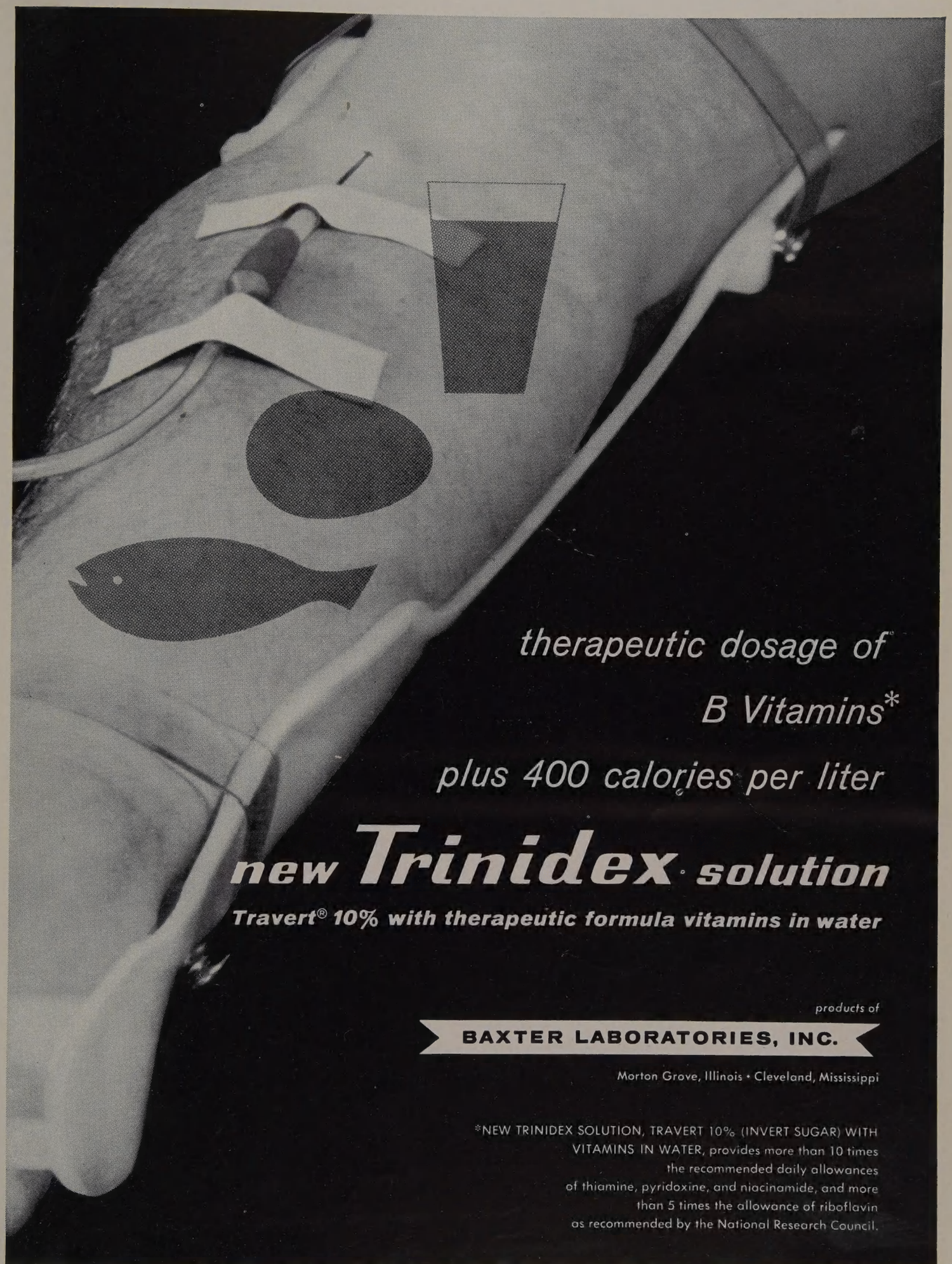
J. Sklar Mfg. Co.

Victor W. Filler, an executive of J. Sklar Manufacturing Co., Long Island City, N. Y., died in New York at the age of 62. Mr. Filler first became associated with Sklar in 1918 and was active in the surgical instrument field until 1953.

E. R. Squibb & Sons

Lewis H. Wright, M.D., a member of the E. R. Squibb & Sons Medical Division for more than 25 years, has been named by the American Society of Anesthesiologists to receive its 1955 Distinguished Service Award.

Advertisers Index



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BEEF IN GRAVY	20.1%
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CHICKEN A LA KING	10.5%
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